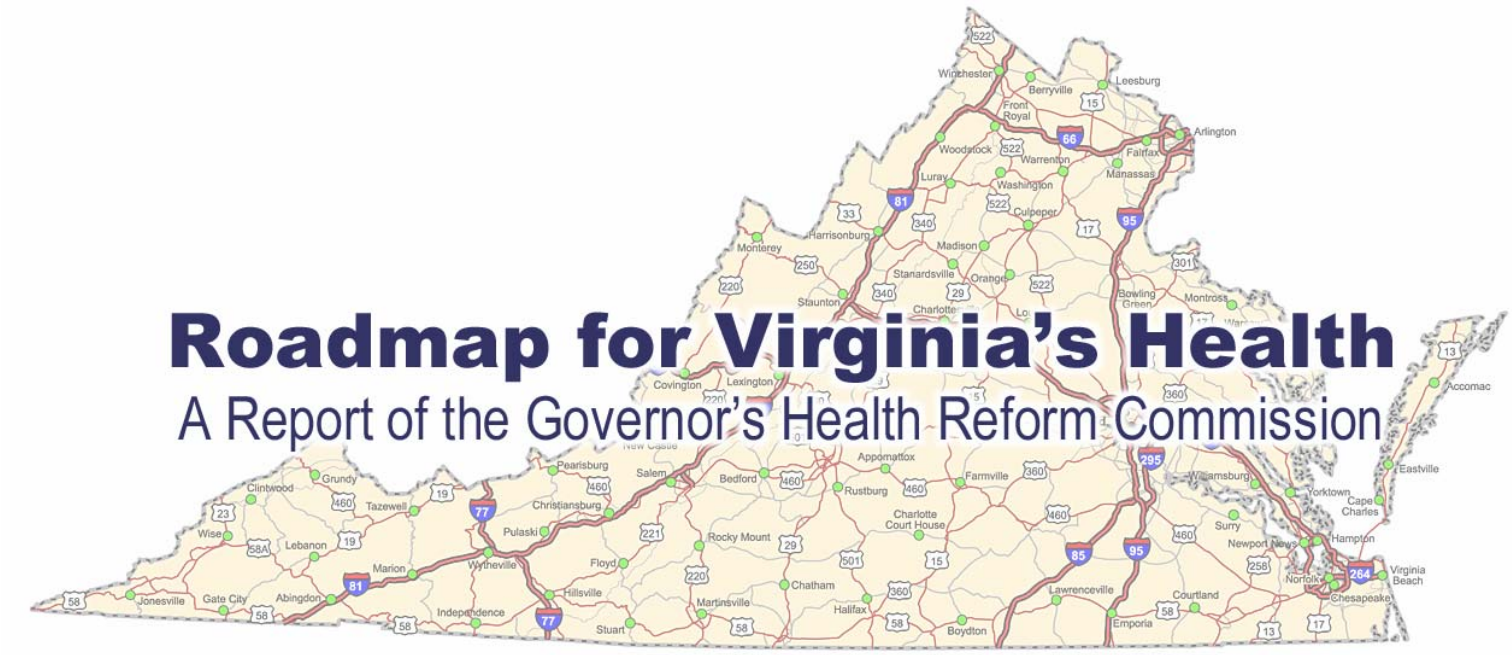

Roadmap for Virginia's Health

A Report of the Governor's Health Reform Commission

September 2007

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ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY FOR A HEALTHIER VIRGINIA

In August 2006, Governor Kaine issued Executive Order 31 (see Appendix A) creating a Health Reform Commission tasked with recommending ways to improve the healthcare system in the Commonwealth. The Commission's tasks have included examining the healthcare workforce, affordability, quality, and accessibility of healthcare in the Commonwealth, the transparency of health information, prevention and wellness efforts, and long-term care. This is the final report of the Health Reform Commission. It lays out a *Roadmap for Virginia's Health* that will ensure success in improving the health status of our citizens.

The executive summary and following report cover in depth the way Virginia must travel in order to improve its health status. The first road to be traversed is enhancing the healthcare workforce. Next, the Commonwealth must address expanding access to care for all Virginians. Then the Commonwealth must focus on improving quality, increasing transparency, and promoting prevention. The final road discussed in this report is advancing long-term care.

The Commonwealth is a successful and highly competitive state. Virginia is ranked as the 7th highest state in per capita income.[1] In 2007, *Education Week* ranked Virginia as the state where "a child is most likely to have a successful life."[2] In addition, the Commonwealth has an attractive business climate, being named the Best State for Business by *Forbes Magazine* in 2006 and 2007.[3] Despite this, the overall health status of the citizens in the Commonwealth does not mirror these accomplishments. In 1998 Virginia was 10th overall among the states in health rankings. Since 1998, Virginia's overall health rankings have declined, dropping to as low as 24 in 2005. In 2006, the Commonwealth was ranked 21st.[4]

Health and wellness across the U.S. and the Commonwealth have been and continue to deteriorate at a significant rate. Americans have typically had one of the highest life expectancies. However, over the past decades the U.S. has begun slipping in the international rankings of life expectancies. The U.S. life expectancy is currently ranked 42nd in the world, down from 11th two decades ago.[5] As has been stated time and time again, it does not make sense that one of the richest countries in the world that spends the most on healthcare has such a low ranking. Researchers have found that several factors affect life expectancy as well as general health status.

- One million Virginians are uninsured or 15 percent of our population. Across the nation estimates of the number of uninsured range from 45 to 48 million.
- In the Commonwealth the statistics about obesity and overweight are alarming; nearly 60 percent of adults are overweight or obese, while 39.2 percent of children are overweight or at risk of becoming overweight.[6] The U.S. has one of the highest obesity rates in the world, with nearly one third of the population aged 20+ being obese and nearly two thirds being overweight.[7]
- Racial disparities persist across the country and in the Commonwealth. Virginia is taking a closer look at these disparities with a new Office of Minority Health and Public Health Policy.

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[1] U.S. Census Bureau. (February 2006). *State Rankings – Statistical Abstract of the United States*. Retrieved June 27, 2007, from: http://www.census.gov/statab/ranks/rank29.html.

[2] Education Week. *From Cradle to Career*. Retrieved August 2, 2007, from: http://www.edweek.org/media/ew/qc/2007/17shr.va.h26.pdf.

[3] Badenhausen, K. (2007). *The Best States for Business.* Retrieved August 2, 2007, from: http://www.forbes.com/2007/07/10/washington-virginia-utah-biz-cz_kb_0711bizstates.html.

[4] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

[5] National Center for Health Statistics. *U.S. Life Expectancy Lags Behind Other Countries.*

[6] Virginia Department of Health, Office of Family Health Services.

[7] National Center for Health Statistics. *U.S. Life Expectancy Lags Behind Other Countries.*

- Virginia is ranked 32nd among the states for its infant mortality rate of 7.4 deaths per thousand live births.[8] The U.S. has a much higher infant mortality rate compared to other industrialized countries, with 6.8 deaths per thousand live births.
- Virginia's and the nation's population are aging at a fast rate. The segment of the population with fastest growth rate is 85+.[9] This is projected to be the fastest growing segment across the state and nation until 2050. Currently, 12 percent of Virginia's population is 65+, compared to 11 percent for the nation.[10]

The Health Reform Commission members believe the time for Virginia's policymakers to act is now. This report lays out the steps necessary to reduce infant mortality, racial disparities, obesity, the number of uninsured, and make many other changes that will improve our healthcare system. Each chapter of the report outlines a new mile that must be traversed on our healthcare highway to create a healthier Commonwealth.

This is a call to action for the Commonwealth. The Commission challenges the Commonwealth, business community, advocates, public health, payors, providers, lobbyists, schools, and the citizens of the Commonwealth to make Virginia one of the top ten healthiest states in the nation. This report puts forward strategies that if implemented and funded appropriately will ensure the Commonwealth is successful in raising its overall health ranking and ensuring a healthy future for all Virginians.

The 32-member Health Reform Commission convened in October 2006 and broke into four Workgroups to examine the issues outlined in the executive order. The Workgroups were: (1) Access to Care, (2) Quality, Transparency, and Prevention, (3) Healthcare Workforce, and (4) Long-Term Care. Members of the Workgroups were either Governor-appointed Commission members or invited to participate in the Workgroup because of their expertise. For a full listing of Commission and Workgroup members, please see Appendices B and C. Each Workgroup was given a particular charge as detailed below. The Commission did not address mental healthcare services and delivery because of the work of Chief Justice Hassell's Commission as well as the Commission addressing the tragedy at Virginia Tech in April 2007.

Table 1: Workgroup Descriptions

Workgroup	Mission
Access to Care	• Identify age groups, regions, populations where un-insurance rates are high • Identify methods to improve access to health and health insurance for these groups • Recommend Medicaid changes, funding opportunities, innovative pilots, demonstrations, or small group/individual market reforms to foster change
Quality, Transparency, & Prevention	• Recommend ways to increase transparency of healthcare information for consumers • Improve quality of care for citizens through innovative programs • Identify innovative approaches to improving infant mortality rates, reduce obesity, and reduce tobacco use
Healthcare Workforce	• Bring together stakeholders to examine physician, nursing, and direct support professional workforce shortages in Virginia • Identify ways to increase the number of highly qualified physicians, nurses, and direct support professionals in all areas of the state
Long-Term care	• Understand Virginia's current long-term care system • Identify ways to improve access to long-term care services for all Virginians,

[8] Virginia Department of Health, Office of Family Health Services.

[9] Joint Legislative Audit and Review Commission. (January 2006). *Impact of an Aging Population on State Agencies*. House Document No. 10. Retrieved July 16, 2007, from: http://jlarc.state.va.us/Reports/Rpt329.pdf.

[10] Weldon Cooper Center for Public Service. (2006). *Demographic Profile of Virginia*. Retrieved August 17, 2007, from: http://vaperforms.virginia.gov/VirginiaProfile2006.pdf.

regardless of age group, ability pay, or disability
- Seek out innovative models to enhance consumer and flexibility in choosing care

ENHANCING THE HEALTHCARE WORKFORCE

The U.S. Government Accountability Office noted in their February 2006 report "*Health Professions Education Programs – Action Still Needed to Measure Impact*," that regular reassessment of future health workforce supply and demand is crucial to setting policies as the Nation's healthcare needs change.[11] There are numerous factors affecting the adequacy and quality of the healthcare workforce in the Commonwealth including: demographics of the Commonwealth, demographics of the healthcare workforce, changes in technology, rate of the uninsured, and the deteriorating health status of the citizens of Virginia. In order to provide access to quality care, it is imperative that there be a healthcare workforce in the Commonwealth that is not only currently strong and of high quality, but that has a pipeline of individuals ready to take on responsibilities as the current workforce begins retiring.

A basic component of Virginia's infrastructure imperative for regional economic growth is a sound healthcare system. Healthcare providers contribute significantly to regional economic conditions as employers. Presently in the Commonwealth, the healthcare industry is very strong, ranking 7th among the state's industrial sectors. For the 4th quarter of 2006, there were 12,462 healthcare employers in Virginia or 5.8 percent of the state's 215,201 employers. In addition, in 2006 the state's 245,000 healthcare jobs comprised about 6.2 percent of all state jobs and there were approximately 9,600 annual job openings. Health facilities have a greater likelihood of reduced revenues and an increased risk of closing when they are short staffed. When these facilities are not adequately supplied, employees are not capable of providing sufficient access and quality health services within their communities. Therefore, the healthcare workforce shortage not only has implications for the quality of healthcare provided to Virginians, but also affects the Commonwealth's ability to attract and retain employers.[12][13]

Physicians

It is estimated that by 2020 there will be a shortage of approximately 1,500 physicians in the Commonwealth. Physician retention is the primary issue in the supply of the physicians in the Commonwealth. Table 2 below depicts some glaring statistics that show the Commonwealth must improve its retention of medical students, residents, and fellows if there is to be an adequate supply of physicians in the future.

Table 2: Physician Workforce Statistics[14][15]

	U.S.	Virginia	Virginia's Rank
Active physicians 100,000 population	245.6	238.3	21
Physicians in residencies and fellowships per 100,000 population	34.3	27.5	23
Number of current medical students educated per 100,000 population	26.6	25.0	22
Active physicians in-state who completed a residency or fellowship in state	44.7%	28.0%	35
Active physicians in-state that attended in-state medical schools	29.6%	25.0%	30
Retention of residents and fellows	47.6%	38.0%	38

[11] Bureau of Health Professions. (2006). *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand*.

[12] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

[13] Virginia Employment Commission. (2006).

[14] Mick, S. (2007). A *Physician Shortage: Will It Exist in Virginia by 2010 and 2015? Preliminary Findings for the Virginia Workforce Committee*. Virginia Commonwealth University: Richmond, VA.

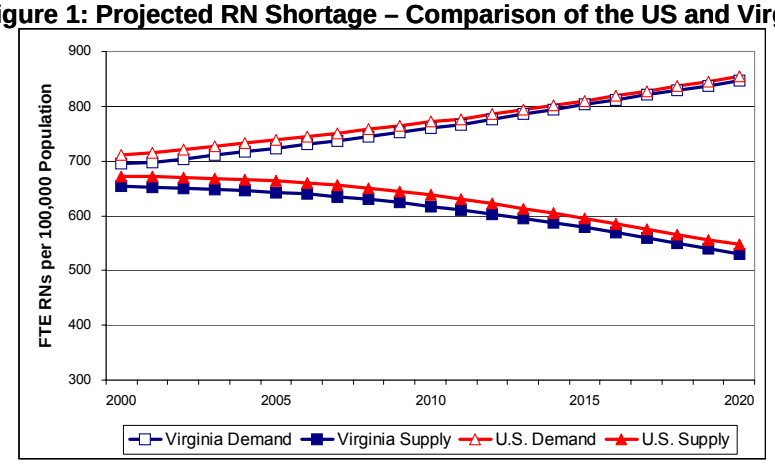
[15] Center for Workforce Studies. (2006). *Key Physician Data by State with Virginia Highlights*. Association of American Medical Colleges.

Retention of medical students	39.0%	36.0%	29

Nurses

The demand for full-time equivalent RNs in Virginia is expected to increase by roughly 43 percent between 2000 and 2020, meanwhile supply of RNs is not expected to keep pace. By 2020, it is expected that in the Commonwealth there will be a shortage of 22,600 RNs or 32.6 percent. To meet this demand it is expected that RN supply will have to increase by 60 percent. As seen in Figure 1 below, Virginia is projected to have a significant shortage of nurses, one that mirrors the shortage nationwide.[16] Not only is there a shortfall between RN demand and RN supply, but due to the shortage in educators and facilities, there is also a shortfall between the number of students Virginia can currently educate each year and the level of interest in pursuing a career as an RN. This is particularly unfortunate given the high number of qualified applicants that are denied admission to nursing programs due to program capacity limitations. In 2003, programs throughout the Commonwealth had to turn away more than 1,300 qualified applicants. This problem persists today, and the number of qualified applicants being turned down continues to grow both across the country and in Virginia.[17]

Figure 1: Projected RN Shortage – Comparison of the US and Virginia



Data Source: National Center for Health Workforce Analysis, BHPr, HRSA

Direct Support Professionals

Direct Support Professionals (DSPs) take on many different roles including: certified nurse aides, orderlies, attendants, home health aides, personal care aides, home care aides, personal care attendants, psychiatric aides, direct care workers, direct services associates, paraprofessionals, medication aides, and community health workers. This segment of the workforce attends to the elderly, disabled, and others in long-term care settings. They work in hospitals, nursing homes, residential and assisted living facilities, adult day cares, people's homes, home health agencies, and other long-term care settings. They provide a significant amount of the care received by clients in long-term care settings and/or with long-term care needs. This care includes both physical care and emotional support and companionship.

Virginia's long-term care support system includes a network of institutions, federal and state funded community programs administered through various agencies, and over two hundred home health service providers. According to a survey by the American Healthcare Association in 2002, the statewide vacancy rate for Virginia certified nurse aides, was 8.2 percent, and the turnover rate was 73.2 percent. It is expected that these numbers will continue to worsen as the population ages.[18] Figure 2, shows the

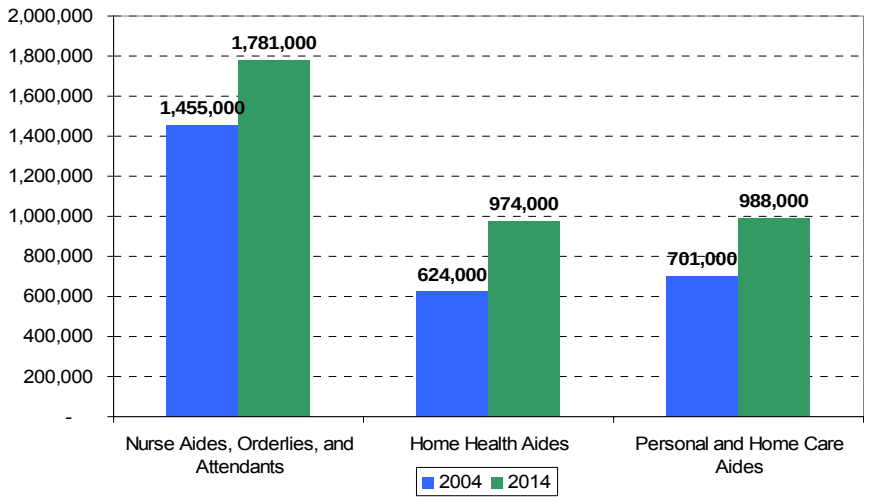
[16] Maddox, P.J. (2007). *Today is the 'Good 'Ole Days': Virginia's RN Workforce Trends.* George Mason University: Fairfax, VA.

[17] Health Reform Commission. (November 2006). *The Nursing Shortage: Workforce Subcommittee Meeting*. Richmond, VA.

[18] American Healthcare Association. (2003). *Survey of Nursing Staff Vacancy and Turnover in Nursing Homes*. Retrieved July 20, 2007, from: http://www.ahca.org/index.html. Washington, D.C.

distribution of some segments of the direct support professional workforce for Virginia. These numbers have been fluctuating and showing very little growth. Coupling this with the turnover and vacancy rates, the 'care gap' between those needing care and those available to care will widen.

Figure 2: Projected Growth in Direct Support Professional Jobs, 2004 - 2014



Source: U.S. Bureau of Labor Statistics May 2005

The Workforce section of the Health Reform Commission (Commission) Report covers at length the three areas, physicians, nurses, and direct support professionals, reviewed by the Commission. There is a segment dedicated to each of these areas. Each segment includes information regarding the national workforce shortages, the effects the shortages have on Virginia, and why the Commonwealth should pursue policy change to address these concerns. Each section ends with recommendations that the Commission believes the Commonwealth should begin implementing.

Recommendations and Estimated Costs

Table 3: Pricing of Workforce Recommendations (Annual Estimated Costs)

Overall Healthcare Workforce		
Establish a healthcare data workforce center housed within the Department of Health Professions charged with improving data collection and measurement of the healthcare workforce	$	600,000
Physician Workforce		
1A. The Governor should increase the retention rates of both medical students and residents through: a. Provide funding to the Office of Minority Health and Public Health Policy (OMHPHP) to increase staffing so that OMHPHP can more aggressively market Virginia programs and the state as an option b. Increase funding for existing scholarship and loan repayment programs c. Increase the number of GME slots and salaries for residents	$	2,864,377
1B. Provide funding for increased staff support for designations of Federal Health Professional Shortage Areas (HPSAs), Federal Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs)	$	176,623
2A. Require all University Presidents submit strategic plans, with cost implications, that identify enrollment capabilities and resource requirements to increase medical school class size	$	0
2B. Provide funding to cover increased teaching time	$	2,500,000
2C. Provide grant funding to medical schools for implementing innovative practices that will change the medical educational model to produce additional and higher quality physicians	$	10,000,000

2D. Increase physician productivity through use of physician extenders	$	1,000,000
3A. Maintain medical malpractice caps	$	0
3B. Incent EHR adoption through grants and help desk concept	$	1,000,000
Subtotal Physician Workforce Recommendations	$	17,541,000
Nursing Workforce		
1A. Require all University Presidents and the Chancellor of the Virginia Community College System to submit strategic plans, with cost implications, that identify enrollment capabilities and resource requirements to increase basic nursing programs (pre-licensure) by 50 percent and 100 percent.	$	0
1B. Provide funding to expand current and new masters programs	$	5,000,000
1C. Provide funding for educational capacity increase through: a. Increased general fund appropriations and block grants b. Formula funding systems to allocate appropriated funds	$	10,000,000
1D. Provide grant funding to nursing schools for implementing innovative practices that will change the nursing educational model to produce additional and higher quality nurses	$	2,000,000
2A. Develop legislation that removes barriers for retired state employee nurses so that they may reenter the workforce while collecting retirement	$	0
2B. Increase the number of doctoral and masters level students, who are focused on becoming educators, through increased funding to existing scholarship and loan repayment/assistance programs that have service requirements requiring teaching in the Commonwealth	$	500,000
3A. Modify reimbursement methodologies to the direct reimbursement of nursing care. This would include: a. Studying a Pay-For-Performance program that uses nurse sensitive indicators to pay hospitals and implement if appropriate.	$	0
Subtotal Nursing Workforce Recommendations	$	17,500,000
Direct Support Professional Workforce		
1A. Replicate the Department of Medical Assistance's Demonstration to Improve the Direct Service Community Workforce in six pilot sites across the Commonwealth*	$	1,036,800
1B. Provide funding for scholarship and loan repayment programs for the direct support professional workforce that includes one year service requirements	$	50,000
1C. Develop pilot programs to implement integration of Workforce Investment Boards, Social Services, and One Stops to place more TANF recipients in direct support professional roles	$	1,000,000
1D. Create a social marketing campaign that creates a positive image of direct support professionals and demonstrates the importance of this workforce	$	1,000,000
1E. Enable the WIBs, through legislation, to have a sector strategy for direct support professionals	$	0
Subtotal Direct Support Professional Workforce Recommendations	$	3,086,800
*This funding would be for three years for the six pilots and would all be appropriated in year one		
Total for all Workforce Recommendations	**$**	**38,127,800**

EXPANDING ACCESS TO CARE

More than 1.1 million Virginians—15.5 percent of residents—are uninsured.[19] One in five adults lack coverage compared to one in eleven children. While the vast majority of privately insured Virginians secure their coverage through their employers, there has been erosion of employer-based coverage during the past ten years. Thus, despite the relatively healthy economy in the Commonwealth, some striking statistics indicate the need to examine new ways to provide health coverage for the uninsured:

- Nearly 70 percent of the uninsured live in households with at least one full-time worker (Figure 1).[20]
- The self-employed and those working in firms with fewer than 100 employees account for the majority of uninsured.[21]
- Nearly three-quarters of uninsured Virginians report they live in households where there is no offer of employer-sponsored health insurance.[22]
- Nineteen to 34 year olds have the highest rate of un-insurance among non-elderly adults—nearly 27 percent do not have health insurance.[23]
- Uninsured rates are significantly higher for those living in poverty compared to those with incomes above 300 percent of the Federal Poverty Level (FPL).[24]

The significant number of uninsured Virginians indicates an ongoing challenge for the Commonwealth. While safety net providers and the Medicaid and FAMIS programs are providing valuable services to low-income and/or uninsured Virginians, rising demand for these programs may soon outpace resources. The number of low-income working uninsured residents, young adults without health insurance, and the number of businesses that are not offering coverage to their employees indicates that the current network of safety net care, Medicaid, FAMIS, and private health insurance are not meeting the needs for a substantial group of Virginia's residents. New options and vehicles need to be developed to make health insurance and healthcare services accessible and affordable for all residents. Increased access to the most basic primary healthcare for Virginia's one million uninsured residents can improve worker productivity, reduce chronic illness, and improve overall population health outcomes in the Commonwealth.

The Access to Care Workgroup sought to identify options that will provide access to care or health insurance for the greatest number of people and will provide the greatest return on investment. The Access chapter of this report discusses these options in detail. Given the broad scope of the access problems in the Commonwealth and the limited time to formulate recommendations, the Workgroup advocates options that can be implemented effectively within a short amount of time and reach a significant number of the uninsured. The recommendations outlined, if fully implemented could reach over 100,000 uninsured Virginians during the first two years of implementation.

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[19] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[20] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[21] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[22] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[23] Joint Legislative Audit and Review Commission. (January 2007). *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*. House Document No. 19. Retrieved July 16, 2007, from: http://jlarc.state.va.us/Reports/Rpt349.pdf.

[24] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

Recommendations and Estimated Costs

Table 4: Pricing of Access Recommendations (Annual Estimated Costs)

1A. Annually or biennially study Virginia's uninsured population	$ 0
1B. Evaluate Medicaid provider access biennially	$ 0
2A. Provide $10 million in state General Funds to the community-based healthcare safety net annually	$ 10,000,000
3A. Expand Medicaid eligibility to 100% FPL for parents and caretaker adults ages 19-64 (includes 3B)[25]	$ 84,000,000 - $ 127,500,000
3B. Include routine dental services as part of any Medicaid eligibility expansion for parents, or include routine dental services for existing parents enrolled in the Medicaid program	See 3A
3C. Expand FAMIS eligibility from 200% FPL to 300% FPL for children[26]	$ 2,000,000
3D. Increase FAMIS eligibility for pregnant women from 185% FPL to 200% FPL	$ 1,600,000
4A. Create a private health insurance product for uninsured Virginians with incomes less than 200% of FPL who have no other access to public or private health insurance	$ 20,000,000
Total	**$ 117,600,000- $ 161,100,000**

[25] Joint Legislative Research and Audit Commission. (January 2007). *Range Reflects Preliminary DMAS Estimates Based on CPS Data.* House Document No. 19.

[26] Preliminary DMAS estimate. Does not include additional Medicaid and FAMIS costs associated with reaching currently eligible, but not enrolled children.

IMPROVING QUALITY

During the 2006-2007 legislative session, the Department of Medicaid Assistance Services (DMAS) was directed by the Virginia General Assembly (via HB 2290) to develop a Nursing Facility Quality Improvement Program. Similarly, the State Appropriation budget mandate further directed DMAS to develop a pay-for-performance (P4P) proposal for Medicaid nursing homes. In light of these legislative actions, the Quality, Transparency, and Prevention Workgroup focused on ways it could provide input to help shape this quality improvement effort; the Workgroup did not evaluate the merits of P4P methods in promoting quality in public sector care.

The use of pay-for-performance incentives is based on the premise that current payment systems do not promote quality and may at times reward poor performance and poor practices. Aligning payment incentives with desired outcomes creates opportunities to use financial rewards to encourage the use and adoption of evidence-based care processes and best practices. The success of a P4P program will be determinant upon its design, implementation, evaluation, and continued refinement. Key to each stage will be to ensure "buy-in" from participants, the use of meaningful metrics, and the provision of appropriate rewards linked to quality outcomes. A sustainable P4P system can be one tool used to steer individuals and entities towards valuing a culture dedicated to high performance, safety, and quality.

The implementation of P4P programs designed for nursing facilities has been pursued by at least eleven states, although not all remain active. States that have implemented quality reimbursement programs for nursing facilities have used a variety of measures to assess quality and reward high performance. The mix of measures typically used includes minimum data set (MDS) measures on resident outcomes, staffing measures, certification survey deficiencies, and resident and family quality of life or satisfaction scores. The reward structures from each state program also vary and include both non-financial and financial incentives.

Recommendations and Estimated Costs

Table 5: Pricing of Quality Recommendations (Annual Estimated Costs)

1. Include the use of meaningful metrics linked to quality improvements that balance both absolute and relative scales A. Begin as a voluntary program B. Pilot test the proposed measurement system	
2. Incorporate, at a minimum, MDS, staffing, satisfaction, and survey criteria into the measurement components for quality A. Update, modify, and improve the P4P system over time to include additional metrics targeting specific areas the Commonwealth would like to address, such as avoidable hospitalization rates.	
3. Fund through new monies A. Incorporate both financial and non-financial incentives B. Reward innovation, modernization, and culture change that promote quality in resident care	
4. Evaluate and monitor the program regularly to assess effectiveness, with an annual report due to the Secretary of Health and Human Resources	
5. Increase transparency between consumers and nursing facilities by making quality performance scores publicly available through a website or other accessible means A. Provide consumers with an additional tool to compare and select nursing facilities.	
Total*	**$ 7,000,000 – $16,000,000**

* Based on other state programs, the incentive payment budget is generally 1-2 percent of reimbursement rates. In Virginia, this would equate to $7-8 million or $14-16 million.

INCREASING TRANSPARENCY

Over the last decade, there has been a push for increased transparency and accountability in the healthcare sector, yet pricing and quality often remain a mystery to most consumers. This is due to the complex nature of the pricing system found in the sector. When discussing healthcare pricing, charges are often discussed, yet most people do not pay based upon charges. For those with insurance, their insurer may have negotiated a specific discount on the charges, or may pay based on a percent of charges, a per diem rate, or other negotiated rate. For those without insurance, most providers are working to provide similar discounts or care is provided for free. This makes pricing transparency extremely challenging because providing information on charges does not really mean anything to most consumers, and asking insurers and providers to provide detailed information on what is actually paid gets at the heart of contract negotiations and may be considered proprietary information.

In addition, defining transparency and its intent has often been a challenge. Simply presenting cost information may not be that meaningful to consumers. Consumers need information that helps them understand their financial obligation for an episode of care, not just a procedure. In addition, quality information must be a part of the equation or consumers may be driven to go the highest cost provider, assuming that higher cost means better quality. The converse could also happen, i.e. the consumer could opt for lowest cost provider with no information on the quality of the provider. In essence, being transparent on prices does not mean much if that pricing is not put into context with quality and episode of care information.

The push for transparency is occurring for many reasons including a greater focus on increased consumerism and personal responsibility in healthcare. This has been evidenced through the development of high deductible health plans, health savings accounts, and higher co-pays and co-insurance. In addition, the rising costs and inflation rates seen in healthcare indicate that something must be done or the "system" we currently have will not be maintained. Pricing, quality, and information transparency is believed to be one method that could begin to help control/reign in costs.

Recommendations and Estimated Costs

Table 6: Pricing of Transparency Recommendations (Annual Estimated Costs)

1.	Develop and implement a single portal (through VHI) for the dissemination of useful, transparent information on healthcare costs and quality to consumers	
2.	Use the best practices identified by the AQA alliance and support efforts by the Virginia Healthcare Alliance to obtain AHRQ grants to develop Virginia's quality measures	
3.	Require public and private payors provide VHI a reasonable range of amounts paid by the payor for specific procedures by geographic areas within the Commonwealth	
4.	Convene a stakeholder group to work with VHI and the Health IT Council to determine the best method for securing the appropriate and most useful pricing information from public and private payors	
5.	Include general healthcare information and links to other important sites for information, in order to create a true one-stop-shopping portal for Virginians to access important healthcare information	
6.	Develop and implement a public-private marketing plan to make Virginians aware of the new transparency portal and the valuable healthcare information that can be accessed through the VHI portal	
7.	Ensure the portal developed is accessible to all Virginians	
	Total*	**$ 454,750**

* Total estimated cost for three years not including a marketing plan and the additional insurer information

PROMOTING PREVENTION

In 1998 Virginia was 10th overall among the states in health rankings. Since 1998, Virginia's overall health rankings have declined. The following chart displays the steady down turn in the quality of health of Virginians:

Table 7: Virginia's Overall Health Ranking Among the Fifty States (1998 – 2006)[27]

Year	Rank	Year	Rank
1998	10	2003	21
1999	14	2004	20
2000	14	2005	24
2001	15	2006	21
2002	18		

Virginia's ranking has been fluctuating since 2003. This inconsistency is unacceptable. The quality of health, specifically reducing the infant mortality rate, the prevalence of obesity, and the use of tobacco, must be improved. Virginia was ranked 33rd in the nation in 1990 and 32nd in 2006 for its infant mortality rate. The Commonwealth has remained steady in this category; however, due to increased access to prenatal care and the economic status of the state, infant mortality should be waning at a much more significant rate. Obesity is on the rise in the Commonwealth. In 1990, Virginia ranked 9th among the 40 states in having the lowest prevalence of obesity. In just one year, from 2005 to 2006, Virginia's ranking dropped from 24th out of 40 states in the prevalence of obesity to the current 28th position. The obesity epidemic is widespread and adversely affecting the quality of health in the Commonwealth. Finally, in 1990 Virginia ranked 42nd in prevalence of tobacco use. In 2006 the state improved to the 25th position. This is an area where Virginia has made substantial progress over the past fifteen years, but there is still much to be done.[28]

Virginia is a leader among states in many areas. The vision for the Commonwealth is to be consistently ranked in the top ten healthiest states for the overall ranking. In 2004 and 2005 the infant mortality rate in Virginia was 7.4 deaths per 1,000 live births. The goal is to reduce this to 7.0, a 5 percent reduction in infant deaths, by the end of FY 2009. In 2004, 24 percent of Virginians were obese and the goal is to reduce this number to a maximum of 20.5 percent, a 15 percent reduction, by the end of FY 2009. In 2006, Virginia was ranked 25th for tobacco use with 20.6 percent of adults over the age of eighteen smoking. By the end of FY 2008, Virginia should reduce its adult smoking rate to 19 percent and its youth smoking rates to 14.5 percent.[29]

Recommendations and Estimated Costs

Table 8: Pricing of Prevention Recommendations (Annual Estimated Costs)

Overall Prevention Recommendations	
Establish a non-profit foundation that will leverage public and private funds to focus on promoting clinical preventive services and healthy lifestyle choices across the Commonwealth	$ 5,000,000
Infant Mortality Recommendations	
1A. Provide the Board of Health with the authority in the Code of Virginia to develop criteria to identify and establish perinatal underserved areas	$ 65,763
1B. Implement one screening tool for pregnant women for all publicly funded programs and make training available to all providers	$ 33,800
1C. Provide additional funding to effective public and private prenatal home visiting programs that meet those criteria established for publicly funded home visiting	$ 6,800,000

[27] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

[28] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

[29] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

1D. Develop, evaluate, and replicate intensive evidence-based interconception care and care coordination models for women at high social and medical risk	$ 631,000
1E. Provide funding to DMAS for dental care to pregnant women in Medicaid and FAMIS Moms	$ 3,100,000
1F. Educate parents and providers regarding SIDS and safe sleep environment	$ 156,000
Subtotal Infant Mortality Recommendations	$ 10,786,563
Obesity Recommendations	
1A. Develop additional incentives to increase school participation in the Governor's Nutrition and Physical Activity Scorecard program	Covered through CHAMPION
1B. Create a bulk purchasing model for healthy foods initially targeting school divisions with the intent to expand to all state agencies	$ 0
1C. Establish state performance benchmarks/goals for physical fitness and BMI through the VA Wellness Related Fitness Test (VWRF)	$ 50,000
1D. Increase funding for the school breakfast and school lunch programs to encourage greater participation and increase nutritional value and nutritious food options	$ 8,005,000
1E. Encourage VDH and DOE to partner to develop lesson plans and instructional tools for nutrition and physical education based upon the health education SOL	$ 104,000
1F. Implement CDC's coordinated school health programs and Youth Risk Behavior Survey to receive additional federal funding	$ 0
2A. Fund the CHAMPION program	$ 676,824
3A. Improve nutritional offerings in all state agency cafeterias, public school cafeterias, public higher education institutions, mental health facilities, correctional facilities, juvenile justice facilities, etc. to follow the American Dietary Guidelines	TBD
Subtotal Obesity Recommendations	$ 8,835,824
Tobacco Use Recommendations	
1A. Promote and create incentives for 24/7 tobacco-free K-12 school grounds	$ 90,000
1B. Promote and create incentives for 24/7 tobacco-free higher education campuses	$ 500,000
2A. Introduce legislation to amend the Virginia Clean Indoor Air Act by prohibiting smoking in indoor spaces within restaurants throughout the state	$ 0
2B. Provide additional funding to the new non-profit prevention collaborative and VDH to enhance QuitNow	$ 3,000,000
3A. Create a benefits package that rewards non-tobacco using state employees for living a healthy lifestyle by offering a discount on the employee portion of their premium	Price neutral
3B. Expand nicotine replacement therapy in State Health Plan	$ 5,800,000
3C. Increase the number of opportunities for state employees to participate in smoking cessation programs from two to four opportunities	$ 30,000
3D. Educate both State Employees and Medicaid beneficiaries about smoking cessation benefits available to them	$ 0
Subtotal Tobacco Use Recommendations	$ 9,420,000
Total for all Prevention Recommendations	**$ 34,042,387**

ADVANCING LONG-TERM CARE

The number of older Virginians is expected to increase substantially over the next 25 years. By 2010, persons over aged 60 will comprise 18 percent of the state's population.[30] By 2030, one in four Virginians will be over the age of 60; this is a 120 percent increase from 2000.[31] At the same time, the population of people with both physical and mental disabilities continues to grow; creating additional care needs, with higher morbidity.[32] In addition, Virginia's population as a whole continues to see increases in the number and types of co-occurring preventable conditions such as diabetes, obesity, and cardiovascular disease, all of which contribute to higher disability rates. Collectively, these growing needs will be a significant challenge for the Commonwealth and the nation.

This momentous population shift is just beginning and it will significantly change the ways the Commonwealth, localities, and long-term care providers offer care in Virginia. Today, long-term care consumers are choosing to remain in their homes or their community as long as possible. The demographic trends and continued drive toward home and community-based services has created and will continue to be a significant challenge for Virginia.[33] The Long-Term Care (LTC) Workgroup members believe all citizens of Virginia, regardless of age or income, have the right to make an informed choice about where to live and receive services whether it be in an assisted living facility, their own home, or a nursing facility. The availability of services such as case management, wellness programs, and other community support programs are critical for people live in community-settings as long as possible.

The LTC Workgroup's recommendations are intended as roadmap for an improved long-term care system. There are items that should and can be implemented now with appropriate performance benchmarks to measure future impact. Other recommendations could be reasonably tied to key benchmarks and implemented over the next five, ten, and fifteen years. The Workgroup evaluated long-term care system gaps in several areas:

a. ***How can Virginia improve the information platform for long-term care consumers, families, and providers?*** Consumers of long-term care services and their families should have easy access to information about all care options. Providers should be able to access information about complementary services or options when consumers are in need.

b. ***How does Virginia encourage people to plan for their future long-term care needs?*** More effort should be placed on educating Virginians about long-term care planning to increase overall awareness and reduce further pressure on public resources.

c. ***How can providers, localities, and the State provide better care coordination?*** The integration of Medicaid and Medicare acute and long-term care through managed care is a critical step in improving care coordination and financing for long-term care.

d. ***How can the Commonwealth increase access to affordable housing and improve housing supports?*** There are inadequate supports and unaffordable housing options for seniors and persons with disabilities who wish to live in the community.

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[30] Joint Legislative Audit and Review Commission. (January 2006). *Impact of an Aging Population on State Agencies*. House Document No. 10. Retrieved July 16, 200, from: http://jlarc.state.va.us/Reports/Rpt329.pdf.

[31] Joint Legislative Audit and Review Commission. (January 2006). *Impact of an Aging Population on State Agencies*. House Document No. 10. Retrieved July 16, 200, from: http://jlarc.state.va.us/Reports/Rpt329.pdf.

[32] Braddock, D. et al. (October 2006). "Morbidity and Mortality in People With Serious Mental Illness." *The State of the States in Developmental Disabilities.* University of Colorado: Boulder, CO.

[33] Home and community-based options identified by the LTC Workgroup include, but are not limited to, home care, personal care services, assisted living, home healthcare, adult day healthcare, and Program for All-Inclusive Care for the Elderly (PACE).

e. ***Can the state and localities increase mobility in the community for long-term care consumers through more accessible and available transportation?*** Without accessible transportation, seniors and people with disabilities find it difficult to live in the community.

f. ***How can providers, the educational system, and the Commonwealth foster the development of a qualified and adequate LTC workforce?*** There are an inadequate number of geriatricians, physician extenders, nurses, nursing support, and direct care workers in the long-term care sector in both rural and urban areas.

g. ***How can Virginia, in concert with providers and localities, increase the number of community-living options?*** More community options must be made available to all seniors and persons with disabilities.

The recommendations of the LTC Workgroup are outlined in detail in the Long-Term Care Chapter as well as Appendix O. The recommendations will help Virginia maximize alternative funding streams and bolster the state's commitment to innovation in long-term care. The recommendations, if effectively implemented, will:

- Reinforce Medicaid's current pathway to more integrated and consumer-driven long-term care;
- Expand the availability of the most fundamental aspect of community living—housing;
- Dramatically increase the number of people planning for their future long-term care needs;
- Provide consumers, providers, and caregivers with access to a seamless coordinated system of information and decision-making tools;
- Provide additional support to families as caregivers;
- Provide options to enhance quality of life and delay unnecessary or premature institutionalization; and
- Significantly increase the availability and scope of integral services for all seniors and persons with disabilities such as transportation, case management, and respite care.

Recommendations and Estimated Costs

Table 9: Pricing of Long-Term Recommendations (Annual Estimated Costs)

1A. Support continued integration of Medicaid acute and LTC through PACE and managed care models	$ 0
1B. Maximize consumer choice for Medicaid LTC consumers by continuing to provide consumer-directed options (support Money Follows the Person)	($ 975,000)
1C. Provide annual inflation adjustment to all Medicaid home and community-based providers	$ 26,345,078
1D. Rebase personal care 10% and skilled/private duty nursing 10%	$ 15,789,908
1E. Add assisted living to the Medicaid EDCD waiver	$ 15,671,476
1F. Establish case management for low-income seniors and persons with 2+ ADLs as a state plan option	$ 29,022,924
1G. Improve the AG program	$ 500,000
2. Support the creation of a state housing partnership revolving fund with incentives to build housing and supportive services for people with disabilities or frail elderly	$ 5,000,000
3A. Expand No Wrong Door statewide by 2010	$ 2,000,000
3B. Develop an ongoing social marketing campaign to encourage LTC planning and support the LTC Partnership	$ 100,000
3C. Support family and consumer rights though the LTC Ombudsman Program.	$ 913,000
4A. Provide funding to AAAs to increase transportation options for seniors and persons with disabilities	$ 1,250,000
4B. Increase support and funding for family caregivers and study the current network of community-based caregiver support organizations	$ 2,500,000
5A. Gubernatorial designation of the Secretary as the LTC point of accountability	$ 0

5B. Establish a LTC Coordination Council	$	0
5C. Establish a LTC Advisory Council	$	0
5D. Require local long-term care councils to include housing, transportation, and other representatives in their LTC planning processes and establish a mechanism for reporting to the Long-Term Care Advisory and Implementation Councils	$	0
Total	**$**	**98,117,386**

HEALTH REFORM COMMISSION PRIORITIES

The Health Reform Commission's year-long deliberations generated over 40 recommendations. Given the many critical issues facing the Commonwealth, resources for improving the health and human services systems must be balanced with other priorities. This report should serve as a Roadmap for Virginia's Health. Table 10 and 11 lay out several priorities for the Governor and General Assembly's consideration.

The Commission recommends reconsideration of the other priorities identified in this report prior to the next biennium. In addition, some priorities in lower tiers should be reevaluated if the federal climate changes. The most prominent example of this is the recommendation to expand eligibility in the FAMIS program. Currently, there is a federal SCHIP reauthorization debate underway. Once it is resolved the Governor and General Assembly may wish to move the Tier 2 FAMIS Expansion priority to a higher priority to advantage of any new federal matching funds available to Virginia.

Table 10: Priorities of the Health Reform Commission (Annual Estimated Costs)

First Tier Priorities		
Workforce	Healthcare Workforce Data Center	$ 600,000
	Physician Retention – Increased staff support for federal designations	$ 176,623
	Direct Support Professional Loan Repayment Program	$ 50,000
	Replicate DMAS PCA Grant in 6 sites*	$ 1,036,800
Access	Working Uninsured Option	$ 20,000,000
	Increase Safety Net Funding	$ 10,000,000
All Prevention	Prevention Collaborative	$ 8,000,000
Quality	Medicaid Pay for Performance Program for Nursing Homes	$ 8,000,000
Long-Term Care	Obtain Funding to Implement Money Follows the Person Demonstration	($ 975,000)
	Continue support of Acute and Long-Term Care Integration	$ 0
	Subtotal First Tier Priorities	*$ 46,888,423*
Second Tier Priorities		
Workforce	Physician Retention – Loan Repayment (50 additional awards)	$ 2,500,000
	Nurse Retention – Masters/PhD Loan Assistance/Scholarship (30 additional awards)	$ 600,000
Access	Medicaid Expansion to 65% FPL (with routine dental services)[34]	$ 39,700,000
	FAMIS Expansion from 200% to 300% FPL [35]	$ 2,000,000
Infant Mortality	Designate Perinatal Underserved Areas	$ 66,000
	Home Visiting Programs	$ 6,800,000
	Universal Risk Screen	$ 33,000
Obesity	School Breakfast / Lunch	$ 8,050,000
	PE Benchmarks (software cost)	$ 50,000
	Healthy Food Bulk Purchasing - Schools**	$ -
Tobacco Use	Increase State Employee Smoking Cessation Attempts	$ 30,000
	Healthy Lifestyle Insurance Discount***	$ -
Long-term care	Increase Medicaid Personal Care Reimbursement Rate 10%	$ 15,700,000
	Subtotal Second Tier Priorities	*$ 78,499,000*
Third Tier Priorities		
Access	Medicaid Dental Coverage for Currently Enrolled Caretaker Adults	$ 3,200,000
	FAMIS MOMS Expansion (200% FPL)	$ 1,600,000
Transparency	One portal providing transparent information on healthcare costs and	$ 200,000

[34] Preliminary DMAS estimate based on CPS data.

[35] Preliminary DMAS estimate. Does not include additional Medicaid and FAMIS costs associated with reaching currently eligible, but not enrolled children.

	quality to consumers	
Infant Mortality	SIDS Campaign	$ 156,000
Long-term care	Continue No Wrong Door Implementation	$ 2,000,000
	Subtotal Third Tier Priorities	*$ 7,156,000*
	Total	**$129,573,423**

*This covers three years of costs for 6 pilot sites. The funds are all appropriated in year 1
**Charge school divisions a fee to have access to bulk prices which can cover the cost of the program
***Renegotiate Anthem contract to include at no additional cost to the state

Table 11: Priorities of the Health Reform Commission, Legislation and Other

Area	**Legislation**
Workforce	Expand scope of practice for physician extenders Remove barriers for State Employees to reenter nurse workforce Enable WIBs to have sector strategy, specifically nursing and direct support professionals
Access	Evaluate Medicaid provider access biennially Annually or biennially study Virginia's uninsured population
Prevention	CDC School Health Program Amend Clean Indoor Air Act
Long-Term Care	Establish a LTC Coordination Council Establish a LTC Advisory Council Require local LTC councils to include housing and transportation agencies Study the current network of community-based caregiver support organizations
Area	**Other**
Prevention	Through EO, require all state agencies and institutions to have x% of healthy food options by 2009 Develop additional incentives and support mechanisms to increase school participation in the Governor's Nutrition and Physical Activity Scorecard program

INTRODUCTION TO THE GOVERNOR'S HEALTH REFORM COMMISSION

The following report covers the various avenues Virginia must travel in order to return to being one of the top ten healthiest states in the country. The first road to be traversed is enhancing the healthcare workforce. Next, the Commonwealth must address expanding access to care for all Virginians. Then the Commonwealth must focus on improving quality, increasing transparency, and promoting prevention. The final road the Commonwealth must undertake is advancing long-term care.

Executive Order 31 (see Appendix A) established a Governor's Health Reform Commission to make recommendations to the Governor on how to improve the healthcare system in the Commonwealth. The Commission's tasks included examining the affordability, quality, and accessibility of healthcare in the Commonwealth, the transparency of health information, prevention and wellness efforts, the healthcare workforce, and long-term care. The 32-member Health Reform Commission convened in October 2006 and broke into four Workgroups to examine the issues outlined in the executive order. The Workgroups were: (1) Access to Care, (2) Quality, Transparency, and Prevention, (3) Healthcare Workforce, and (4) Long-Term Care. Members of the Workgroups were either Governor-appointed Commission members or invited to participate in the Workgroup because of their expertise. For a full listing of Commission and Workgroup members, please see Appendices B and C. Each Workgroup was given a particular charge as detailed below.

- **Healthcare Workforce**
  Chairperson: Dr. A. Timothy Garson
  Co-Chair: Karen Drenkard

  This Workgroup must bring together the many existing studies about Virginia's healthcare workforce and identify professions with critical shortages or anticipated shortages. The Workgroup is tasked with examining models from other states to develop a strategy to improve the capacity, skills, and number of healthcare professionals in Virginia. Recommendations should focus not only on bringing people to the professions, but improving the capacity of educational institutions to meet growing demand for services provided by these professionals. The Workgroup will focus on several professions, including the long-term care workforce, which is critical to any recommendations made by the Long-Term Care and Consumer Choices Workgroup.

- **Access to Care**
  Chairperson: Dr. Sheldon Retchin
  Co-Chair: Thomas G. Snead, Jr.

  This Workgroup is tasked with using the many existing sources of data about Virginia's uninsured to identify age groups, regions, or populations where un-insurance rates are high and develop recommendations to the Commission on how to increase the percentage of insured citizens and improve access to care in these areas. The group will recommend innovative pilots, demonstrations, individual or small group insurance market reforms, or other mechanisms to foster change based on the experience within communities, other states, and other nations.

- **Quality, Transparency, and Prevention**
  Chairperson: David Hallock, Jr.
  Co-Chair: Dr. Lorena Harvey

  Today, more than ever, citizens, healthcare providers, and policymakers are focused on reducing medical errors, increasing patient safety, and improving health outcomes. In addition, consumers are being asked to use more tools to manage their own care and make choices about who provides their care. This Workgroup will develop a road map for an integrated, cohesive quality strategy for the Commonwealth. The Workgroup will make recommendations to the Commission about how to increase transparency between consumers and providers, how to use provider data to monitor quality in a systemic and user-friendly manner, and how to reduce medical errors at the site of care. This

Workgroup will also be charged with evaluating obesity, smoking, and infant mortality issues facing Virginia. The group will examine what other states and countries have implemented around these issues and determine if similar models are applicable to Virginia. In addition, this Workgroup will foster innovation and develop creative solutions to combat these three health issues.

- **Long-Term Care**
  Chairperson: William Lukhard
  Co-Chair: Brian Coyne

  This Workgroup will focus on improving long-term care options for seniors and persons with disabilities in Virginia. The group will examine long-term care services for seniors and persons with disabilities of all income groups and identify gaps in coverage for specific groups. The Workgroup will use the experiences of other states, the federal government, and local communities to develop recommendations for the Commission on how to improve access to long-term care services for those with and without Medicaid, educate people about the importance of long-term care planning, and meet increasing demands for services while maximizing consumer choice and flexibility of care.

INTRODUCTION TO THE HEALTHCARE WORKFORCE

The workforce is one of the most critical components of any healthcare system. In order to have a sustainable and ample healthcare workforce, the Commonwealth must begin constructing a path that will enhance its current workforce. Creating a stable workforce will enable Virginians to explore additional avenues to improving overall health. The U.S. Government Accountability Office noted in their February 2006 report "*Health Professions Education Programs – Action Still Needed to Measure Impact*," that regular reassessment of future health workforce supply and demand is crucial to setting policies as the Nation's healthcare needs change.[36] There are numerous factors affecting the adequacy and quality of the healthcare workforce in the Commonwealth including: demographics of the Commonwealth, demographics of the healthcare workforce, changes in technology, rate of the uninsured, and the deteriorating health status of the citizens of Virginia. In order to provide access to quality care, it is imperative that there be a healthcare workforce in the Commonwealth that is not only currently strong and of high quality, but that has a pipeline of individuals ready to take on responsibilities as the current workforce begins retiring.

A basic component of Virginia's infrastructure imperative for regional economic growth is a sound healthcare system. Healthcare providers contribute significantly to regional economic conditions as employers. Presently in the Commonwealth, the healthcare industry is very strong, ranking 7th among the state's industrial sectors. For the 4th quarter of 2006, there were 12,462 healthcare employers in Virginia or 5.8 percent of the state's 215,201 employers. In addition, in 2006 the state's 245,000 healthcare jobs comprised about 6.2 percent of all state jobs and there were approximately 9,600 annual job openings. Health facilities have a greater likelihood of reduced revenues and an increased risk of closing when they are short staffed. When these facilities are not adequately supplied, employees are not capable of providing sufficient access and quality health services within their communities. Therefore, the healthcare workforce shortage not only has implications for the quality of healthcare provided to Virginias, but also affects the Commonwealth's ability to attract and retain employers.[37][38]

Physicians

It is estimated that by 2020 there will be a shortage of approximately 1,500 physicians in the Commonwealth. Physician retention is the primary issue in the supply of the physicians in the Commonwealth. Table 1 below depicts some glaring statistics that show the Commonwealth must improve its retention of medical students, residents, and fellows if there is to be an adequate supply of physicians in the future.

Table 1: Physician Workforce Statistics[39][40]

	U.S.	Virginia	Virginia's Rank
Active physicians 100,000 population	245.6	238.3	21
Physicians in residencies and fellowships per 100,000 population	34.3	27.5	23
Number of current medical students educated per 100,000 population	26.6	25.0	22
Active physicians in-state who completed a residency or	44.7%	28.0%	35

[36] Bureau of Health Professions. (2006). *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand*.

[37] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

[38] Virginia Employment Commission. (2006).

[39] Mick, S. (2007). A *Physician Shortage: Will It Exist in Virginia by 2010 and 2015? Preliminary Findings for the Virginia Workforce Committee*. Virginia Commonwealth University: Richmond, VA.

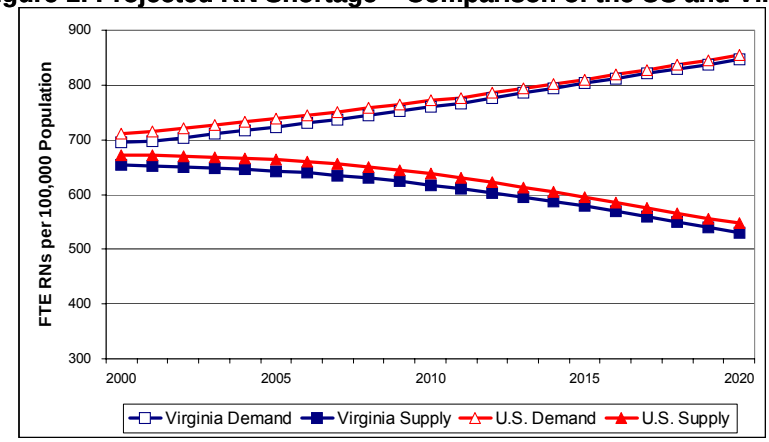
[40] Center for Workforce Studies. (2006). *Key Physician Data by State with Virginia Highlights*. Association of American Medical Colleges.

fellowship in state			
Active physicians in-state that attended in-state medical schools	29.6%	25.0%	30
Retention of residents and fellows	47.6%	38.0%	38
Retention of medical students	39.0%	36.0%	29

Nurses

The demand for full-time equivalent RNs in Virginia is expected to increase by roughly 43 percent between 2000 and 2020, meanwhile supply of RNs is not expected to keep pace. By 2020, it is expected that there will be a shortage of 22,600 RNs or 32.6 percent in the Commonwealth. To meet this demand it is expected that RN supply will have to increase by 60 percent. As seen in Figure 1 below, Virginia is projected to have a significant shortage of nurses, one that is extremely comparable to the US shortage.[41] Not only is there a shortfall between RN demand and RN supply, but due to the shortage in educators and facilities, there is also a shortfall between the number of students Virginia can currently educate each year and the level of interest in pursuing a career as an RN. This is particularly unfortunate given the high number of qualified applicants denied admission to nursing programs due to program capacity limitations. In 2003, programs throughout the Commonwealth had to turn away more than 1,300 qualified applicants. This problem persists today, and the number of qualified applicants being turned down continues to grow both across the country and in Virginia.[42]

Figure 1: Projected RN Shortage – Comparison of the US and Virginia



Data Source: National Center for Health Workforce Analysis, BHPr, HRSA

Direct Support Professionals

Direct Support Professionals (DSPs) take on many different roles including: certified nurse aides, orderlies, attendants, home health aides, personal care aides, home care aides, personal care attendants, psychiatric aides, direct care workers, direct services associates, paraprofessionals, medication aides, and community health workers. This segment of the workforce attends to the elderly, disabled, and others in long-term care settings. They work in hospitals, nursing homes, residential and assisted living facilities, adult day cares, people's homes, home health agencies, and other long-term care settings. They provide a significant amount of the care received by clients in long-term care settings and/or with long-term care needs. This care includes both physical care and emotional support and companionship.

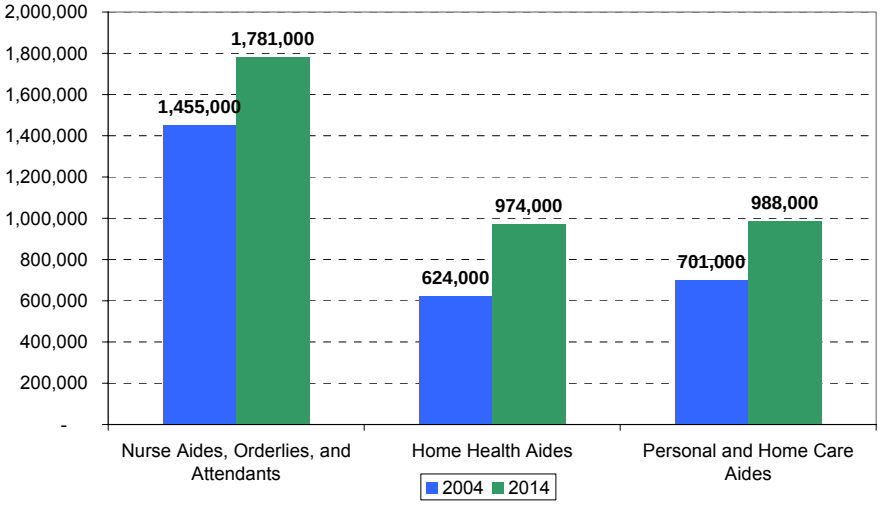
Virginia's long-term care support system includes a network of institutions, federal and state funded community programs administered through various agencies, and over two hundred home health service providers. According to a survey by the American Healthcare Association in 2002, the statewide vacancy

[41] Maddox, P.J. (2007). *Today is the 'Good 'Ole Days': Virginia's RN Workforce Trends.* George Mason University: Fairfax, VA.

[42] Health Reform Commission. (November 2006). *The Nursing Shortage: Workforce Subcommittee Meeting*. Richmond, VA.

rate for Virginia certified nurse aides, was 8.2 percent, and the turnover rate was 73.2 percent. It is expected that these numbers will continue to worsen as the population ages.[43] Figure 2, shows the distribution of some segments of the direct support professional workforce for Virginia. These numbers have been fluctuating and showing very little growth. Coupling this with the turnover and vacancy rates, the 'care gap' between those needing care and care available to those who are in need.

Figure 1: Projected Growth in Direct Support Professional Jobs, 2004 - 2014



Source: U.S. Bureau of Labor Statistics May 2005

The Workforce section of the Health Reform Commission (Commission) Report covers at length the three areas, physicians, nurses, and direct support professionals, reviewed by the Commission. There is a segment dedicated to each of these areas. Each segment includes information regarding the national workforce shortages, the effects the shortages have on Virginia, and why the Commonwealth should pursue policy change to address these concerns. Each section ends with recommendations that the Commission believes the Commonwealth should begin implementing.

OVERALL WORKFORCE RECOMMENDATION

The Workforce Workgroup of the Health Reform Commission developed a recommendation that would apply to all areas of the healthcare workforce throughout the Commonwealth. Initially this recommendation would focus on the three areas the Workforce Workgroup focused on, physicians, nurses, and direct support professionals; however, it could be expanded to focus on the entire healthcare workforce over time and as appropriate.

The recommendation is to create a healthcare data workforce center that would be housed in the Department of Health Professions (DHP). The DHP is the ongoing repository of the names, mailing addresses, initial licensure dates, and education status of the approximately 283,000 licensed health professionals in Virginia. The vast majority of licensees renew their licenses online, and at least 4 of the 13 health regulatory boards have used online voluntary surveys to collect workforce information: Medicine, Nursing, Pharmacy, and Dentistry. Currently in Virginia, there is a lack of accurate healthcare workforce data. If the Commonwealth had the appropriate and necessary data, it would be better to informed on the supply and demand issues in the healthcare workforce and would then be equipped to analyze which strategies are making the most significant difference in diminishing the gap between supply and demand. The DHP would need to work with the Department of Health to ensure collection of appropriate data as well as to establish five year goals and strategies based on the data collected. In

[43] American Healthcare Association. (2003). *Survey of Nursing Staff Vacancy and Turnover in Nursing Homes*. Retrieved July 20, 2007, from: http://www.ahca.org/index.html. Washington, D.C.

addition, the two agencies would work together to track the progress of meeting or not meeting those goals. With accurate information, the Commonwealth would have a better understanding of where it should allocate tax payer dollars. Accurate and appropriate data collection is critical in order to be able to plan for the future and provide access to quality healthcare.

The Board of Nursing (BON) has a "Virginia Nurses Workforce Survey" that is attached to the on-line licensure renewal for both RNs and LPNs. This survey is voluntary and is only available to those people renewing their licensure on-line. In addition, RNs and LPNs renew every other year, so one year of data represents only half the picture. A summary of the questions asked on the survey include the following: level of licensure (LPN, RN, and Advanced Practice), highest degree, number of years licensed as a nurse, gender, employment status (part-time, full-time), primary work environment, primary nursing practice, zip code of work location, satisfaction with nursing employment, number of years planning on working in nursing, and enrollment in a masters degree in nursing. The BON also collects data from nursing education programs. This data is collected annually from all RN and LPN education programs. Data that is collected and reported include: enrollment, graduation rate, attrition rate, licensure exam pass-rate, number of licensees, faculty qualifications, and the number of qualified applicants who are denied admission. This data is presented in the aggregate, but is not analyzed.

The Board of Medicine (BOM) is mandated to report practitioner information, which is available on the website http://www.vahealthprovider.com/. This website has information on over 33,000 current or previously licensed Doctors of Medicine, Osteopathic Medicine, and Podiatry in Virginia. The Board of Medicine, at the behest of the deans of the Virginia medical schools, includes an online survey designed to capture information about Virginia's physician workforce. Doctors of Medicine and Surgery (MDs) and doctors of osteopathic medicine and surgery (DOs) are given the opportunity during online renewal (in even years) to respond to questions that inquire about current work activities, new patient access to initial visits, mid-level practitioners in the practice, plans to expand the number of providers in the practice, and any plans for reduction in hours worked or retirement. Other information that is captured by the survey includes medical school attended, specialty, race, zip code, and year of birth. Similar to nurses, the Commonwealth does not have an annual picture of the physician workforce since the data is collected every other year.

- *The Governor should establish a healthcare data workforce center housed within the Department of Health Professions charged with improving data collection and measurement of the healthcare workforce. This would include but not be limited to the following:*
  a. *Collecting more detailed data including but not limited to: supply and demand information, adequacy of service delivery, geography, etc.*
     1. *For nurses, also evaluate nursing faculty salaries regularly and recommend adjustments as needed to ensure market competitiveness*
     2. *For physicians, also evaluate specialty and geographic distribution of physicians*
     3. *For direct support professionals, also categorize the various career options, training options, certificates, etc. available and determine statewide core competencies and standards*
  b. *Requiring all health professionals to submit requested data to state*
  c. *Developing, implementing, and monitoring two and five year goals and strategies for improving the healthcare workforce; being held accountable for reaching goals*
  d. *Providing annual healthcare workforce supply and demand reports, including progress reports against goals, to the Governor and General Assembly*
  e. *Expanding the scope of VDH's Health Workforce Advisory Committee to monitor progress of all workforce recommendations and reporting to the Secretary of Health and Human Resources on yearly goals and achievements*

ESTIMATED COSTS

Table 1: Pricing of Overall Workforce Recommendations (Annual Estimated Costs)

Establish a healthcare data workforce center housed within the DHP charged with	$	600,000*

improving data collection and measurement of the healthcare workforce

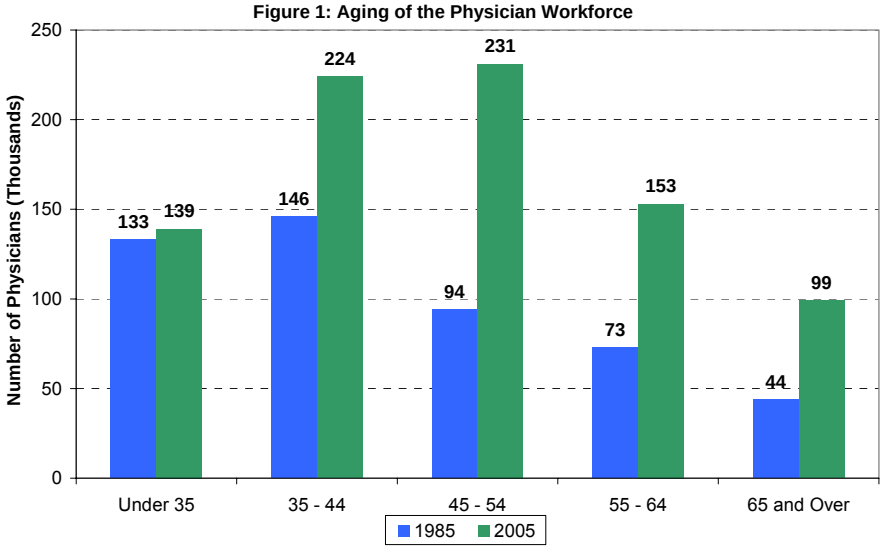
*This is initial funding to get started. Should more funds be needed, DHP could increase fees for licensure and relicensure as needed.

National Physician Shortage

Experts across the country continue to debate the adequacy of the current and future supply of physicians. Accurate projections of physician supply and demand enable the U.S. to provide access to quality care. In the past, projections that showed physician surpluses and shortages have been used to influence policy and programs. Currently, there is a growing consensus that the next 15 years will be marked by an increased need for physician services; particularly for specialist services and specialties that predominately serve the elderly. This groundswell in research findings and interpretation led the Association of American Medical Colleges (AAMC) to encourage growth in the Nation's medical school training capacity by approximately 15 percent or 3,000 physicians per year. [44]

Physician demographics have important supply implications, particularly age and gender as they affect both retirement and workload. As physicians get older, they are more likely to work fewer hours and/or to retire. Figure 1 shows that over time there has been a shift in the age distribution of physicians, indicating more physicians will begin retiring over the next several years. Aside from age, gender also plays a role in the supply of the physician workforce. Currently, 25 percent of the national physician workforce is female. This figure is on the rise for a variety of reasons. Over the past thirty years, there has been an increase from 10 percent to close to 50 percent in the number of female medical school graduates. In addition, the physicians who are currently retiring and nearing retirement age are predominantly male physicians. This increases the proportion of female physicians in the workforce. Finally, work and retirement patterns differ for male and female physicians. Typically, female physicians choose non-surgical specialties, work fewer hours per year, retire slightly earlier, are less likely to work in rural areas, and are more likely to work part-time.[45]

Figure 1: Aging of the Physician Workforce



Source: AMA PCD for 1985 data; AMA Masterfile for 2005 data. Active physicians include

Like physician demographics, the demographics of the country also have an affect on the supply of the physician workforce. In 2012 the baby boom generation will begin turning 65. As a population ages the use of physician services increases dramatically. According to the U.S. Census Bureau, between 2005 and 2020 the populations 65+ is expected to grow by 50 percent compared to a 9 percent growth rate in those aged less than 65. This explosion of the aging population will certainly affect physician supply, potentially requiring more physicians to treat the same number of people.[46]

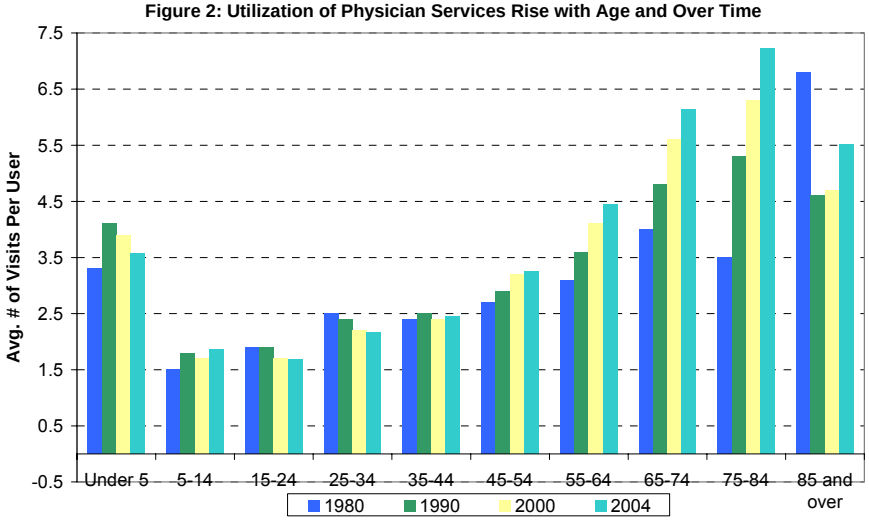
[44] Bureau of Health Professions. (2006). *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand*.

[45] Bureau of Health Professions. (2006). *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand*.

[46] Bureau of Health Professions. (2006). *The Physician Workforce: Projections and Research into Current Issues Affecting Supply and Demand*.

Across the country there has been an increase in chronic diseases. This affects physician workload, which affects the supply of the physician workforce. The eleven costliest medical conditions occur far more often in the elderly population. These conditions include heart disease, trauma, cancer, pulmonary conditions, mental disorders, hypertension, diabetes, arthritis, back problems, cerebrovascular disease, and pneumonia.[47] In addition, cancer is more prevalent among the elderly.[48] Finally, the obesity rates continue to increase at astronomical levels across the country. These population health status changes have significant implications for the both physician and entire healthcare workforce.

Figure 2: Utilization of Physician Services Rise with Age and Over Time



Source: NAMCS 1980, 1990, 2000 &

In 2005, across the U.S., there were 245.6 active physicians per 100,000 population. Comparing this to the other Organisation for Economic Co-operation and Development (OECD) countries, the U.S. ranks 13 out of 20. Germany has the median ratio with 326 physicians per 100,000 population; Greece is the high with 448 physicians per 100,000 while South Korea is the low with 130 physicians per 100,000 population. Australia, New Zealand, Canada and the United Kingdom all have a lower ratio than the U.S.; however, they are all in the process of doubling their number of physicians.[49]

Between 1980 and 2005 the allopathic medical school graduation rates across the country have remained steady, producing approximately 16,000 new medical doctors (MDs) each year. Osteopathic schools graduate approximately 3,000 doctors of osteopathy (DOs) per year. Meanwhile per capita MD enrollment has fallen from a high in 1980 of 7.3 first year MD enrollment per 100,000 population to 5.6 in 2005. This is projected to continually decline over time if current allopathic graduation rates remain, with a projected rate in 2020 of 5.0 first year MD enrollment per 100,000 population. Based on a survey performed by Association of American Medical Colleges (AAMC) in 2005 – 2006, first year MD enrollment appears to be increasing due to increased class size and the potential of five new medical schools opening across the country. The enrollment projection for 2012 is 19,500 first year medical students, 18 percent above 2002 enrollment numbers. Finally, first year enrollment in osteopathic schools is projected to double between 2002 and 2015.

The shortage in the physician workforce, while not projected to affect the nation today, will affect the nation in the future. By 2020, HRSA / Lewin study estimates a physician shortage of 31,900 physicians; other studies have estimated the shortage to be as high as 191,000 physicians. Because of the length of time needed to train physicians, 4 years of undergraduate work, 4 years of medical school, and 3 to 7 years of training depending on specialty chosen, this issue must be addressed today. Changes made today unfortunately will not be recognized for another 11 to 15 years.[50]

[47] Thorpe, K.E., Florece, C.S. & Joski, P. (2004).

[48] Centers for Disease Control and Prevention. (2000). U.S. Cancer Statistics. *Age-Specific Invasive Cancer Incidence Rates by Primary Site and Race, United Sates.* Retrieved July 25, 2007, from: http://www.cdc.gov/.

[49] Simoens, S. & Hurst, J. (2006). *The Supply of Physician Services in OECD Countries*. OECD, Health Working Papers.

[50] Association of American Medical College. (2007). "AAMC Facts" *AAMC Data Book*. Washington, D.C.

Virginia Physician Shortage

In Virginia in 2005, there were 13,907 clinically active full-time equivalent (FTE) physicians. In addition, there are a significant number of residents that can also be added to the physician workforce. Depending how residents are counted, this number increases to between 14,199 and 15,365 clinically active FTE physicians (see Table 1 below).

Table 1: Number of Physicians in Virginia, 2005[51]

	Number of Physicians	Physician: 100,000 Population Ratio
Licensed Physicians in Virginia	16,998	240.0 per 100,000
Active Physicians	16,191	228.6 per 100,000
Clinically Active Physicians (1.0 FTE Residents)	15,365	216.9 per 100,000
Clinically Active Physicians (0.8 FTE Residents)	15,073	212.8 per 100,000
Clinically Active Physicians (0.5 FTE Residents)	14,636	206.6 per 100,000
Clinically Active Physicians (0.2 FTE Residents)	14,199	200.4 per 100,000
Clinically Active Physicians (No Residents)	13,907	196.3 per 100,000

Source: AMA Physician Master File, mid-2005 Release; US Census

The elderly population in the Commonwealth is growing at an increased rate relative to the rest of the nation. In addition, Virginia has a slightly greater representation of female physicians at 28 percent compared to the nation at 25 percent. In Virginia it is projected that, when following the national projection model, a physician shortage will arise in 2015, six years ahead of the projected national tipping point. With an already depressed physician-to-population ratio of 238.3 active physicians per 100,000 in population, Virginia must begin acting now to increase its physician workforce.[52]

Based on the two presentations by Dr. Steven Mick from Virginia Commonwealth University and Dr. Ed Salsberg from AAMC, the Workgroup estimates that by 2020 there will be a shortage of approximately 1,500 physicians in the Commonwealth. This number was used to determine which strategies should be implemented in the Commonwealth.

Virginia's Educational Capacity

The Commonwealth has a strong medical education system with three allopathic and one osteopathic medical school. In addition, Virginia Tech and Carilion have formed a partnership to open another allopathic school. Despite Virginia's high quality medical education system, the benefits of having so many full-time 'physicians-to-be' is diminished by the lack of graduate medical student retention.

Virginia educates about the national average of medical students per-population. Despite this, only 36 percent of Virginia medical students end up practicing in Virginia, while 64 percent of Virginia educated physicians practice elsewhere. The nation as a whole has an average retention rate of medical students of 39 percent. In addition, only 25 percent of Virginia's physician workforce was trained in the state. The remaining 75 percent of the physician workforce is representative of labor importation. Meanwhile the national average is 29.6 percent. Finally, Virginia retains 38 percent of its residents and fellows, while on average this retention rate is 47.6 percent across the nation.[53] [54]

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[51] American Medical Association. (2005). A Physician Masterfile.; US Census Bureau.

[52] Center for Workforce Studies. (2006). *Key Physician Data by State with Virginia Highlights*. Association of American Medical Colleges.

[53] Mick, S. (2007). A *Physician Shortage: Will It Exist in Virginia by 2010 and 2015? Preliminary Findings for the Virginia Workforce Committee*. Virginia Commonwealth University: Richmond, VA.

[54] Center for Workforce Studies. (2006). *Key Physician Data by State with Virginia Highlights*. Association of American Medical Colleges.

Depicted below in Table 2, each of the medical schools in Virginia is planning to expand their class sizes over the next five years. Currently Virginia produces approximately 586 medical school graduates per year. Over the next five years this will be expanded by 166 students for a total of 752 medical school graduates per year. Despite this increase, if current trends continue, the Commonwealth will only retain 36 percent or 271 of these students. Finally, based on the retention rate of 36 percent and an assumption that the increase in class sizes of all medical schools will occur by the 2010 incoming class (meaning the increase in graduates will begin being realized in 2014), the Commonwealth will only produce an additional 418 physicians by 2020. This leaves a shortage of 1,082 physicians indicating the Commonwealth must do a greater job in retaining Virginia medical students to practice in Virginia if it wants to decrease the future gap between supply and demand.

Table 2: Current and Future Class Sizes of Medicals Schools in Virginia[55]

School	Type	Current Graduating Class Size	Potential Class Size Increase
Eastern Virginia Medical School	MD	110	30
University of Virginia	MD	142	30
Virginia College of Osteopathic Medicine	DO	150	0
Virginia Commonwealth University	MD	184	66
Virginia Tech – Carilion	MD	0	40
Total		586	166

If the Commonwealth could work to increase its current retention rate (36 percent) as well as increasing medical school class size, there is a greater chance of stemming this shortage. The tables below show various scenarios in which the retention rate is increased between 5 and 25 percent. These tables assume that the new retention rate and class size increases begin in 2010. It should be noted that if the increase in class size takes place in 2010, the additional physicians being retained will not take affect until 2014 when these physicians begin graduating.

*Table 3: Physician Retention Rate Scenarios – Current Graduating Class**

Scenario	Current Graduating Class Size	Increase Current Retention Rate by:	Additional Physicians Retained/Year	Total Number of Additional Physicians by 2020 (10 years)
1	586	5%	29.3	293
2	586	10%	58.6	586
3	586	15%	87.9	879
4	586	20%	117.2	1,172
5	586	25%	146.5	1,465

*This assumes the retention rate baseline of 36% will remain the same from 2010 – 2020. This table is therefore only calculating the additional number of physicians that will be retained based on the various retention rate increases from 5% - 25%.

*Table 4: Physician Retention Rate Scenarios – Increased Class Size**

Scenario	Potential Class Size Increase*	Retention Rate	Physicians Retained From Increased Class Size/Year	Additional Physicians Retained by 2020 (7 years)
1	166	41%	68	476
2	166	46%	76	535
3	166	51%	85	593
4	166	56%	93	651
5	166	61%	101	709

*Since the increased class size would bring in additional medical students, the increases in retention rate from 5% - 25% were added to the current baseline retention rate of 36% for these calculations.

*Table 5: Physician Retention Rate Scenarios – Total Increase**

Scenario	Additional Physicians Retained from Current Class	Additional Physicians Retained from Increased Class Size	Total Additional Physicians

[55] Health Reform Commission. (March 2007). *The Physican Shortage: Workforce Subcommittee Meeting*. Richmond, VA.

	Size by 2020 (10 years)	by 2020 (7 years)	Retained
1	293	476	769
2	586	535	1,121
3	879	593	1,472
4	1,172	651	1,823
5	1,465	709	2,174

*This table adds the numbers from Tables 5 and 6 to show how many additional physicians would be retained as the retention rate increases by 5% to 25%. Again, this table assumes a retention rate baseline of 36%

WHY PURSUE POLICY CHANGE

Physicians are a key component of any healthcare system. Their contributions to the diagnosis and treatment of illness are critical to the well-being of the Commonwealth's population. As the gap between supply and demand increases, patients will likely have difficulties in scheduling appointments to see their physicians. Meanwhile, time spent with a physician will likely decrease, and physicians will become more overworked, all of which affects access to quality care. A shortage of physicians would result in medical care not being as accessible as it is today and could lead to an increase in the costs associated with health services.

The aging of the population, including physicians, in the Commonwealth is particularly concerning. As the population ages, it will require more services yet more and more physicians will be retiring at the same time. In addition, if the health status of the citizens in the Commonwealth continues to deteriorate, there will be significant implications for the physician workforce. All of the factors are brewing together to create a serious issue in the Commonwealth. If the Commonwealth truly wants access to quality care for its citizen, policy change is necessary to ensure an adequate supply of physicians.

RECOMMENDATIONS

The Workforce Workgroup of the Health Reform Commission (Commission) developed several recommendations concerning the physician workforce in the Commonwealth. Both the Workforce Workgroup and Commission had to narrow the number of recommendations to those that were felt to be of most importance. These recommendations can be broken down into what should be done for physician retention, physician educational capacity, and the private sector. For a listing of all of the recommendations that were evaluated, please see Appendix D.

Recommendations to increase physician retention

A. Given the need for more physicians–both now and considerably more so in the future – several approaches to physician workforce expansion have garnered significant amounts of discussion. As noted above, the Commonwealth has a low retention rate of physicians at 36 percent. Given the relatively immediate need for workforce development, creations of new medical programs is not a feasible primary driver of expansion. The most readily available source of additional physicians is the current medical students and residents in the Commonwealth. A bolstering of incentives and recruiting efforts to these groups is a very viable approach.[56]

- *The Governor should increase the retention rates of both practicing physicians and residents through the following:*
  - *a. Provide funding to the Office of Minority Health and Public Health Policy (OMHPHP) to increase staffing so that OMHPHP can more aggressively market Virginia programs and the state as an option*
  - *b. Increase funding for existing scholarship and loan repayment programs*
  - *c. Increase the number of GME slots and salaries for residents*

[56]Health Reform Commission. (November 2006). *The Physican Shortage: Workforce Subcommittee Meeting*. Richmond, VA.

B. All federal and state programs addressing access to primary care, general dental and mental health services, use the Health Professional Shortage Area (HPSA) and/or Medically Underserved Area (MUA)/Medically Underserved Population (MUP) designation in their respective specialty area as criteria for funding. Additionally, the designation process is required for all of the Commonwealth's recruitment and retention of health professional loan and scholarship programs and all federal recruitment programs. Through lack of staff, the Virginia Department of Health (VDH) is limited in its ability to proactively seek HPSA and MUA designations. Most states have two to three staff dedicated to the designation process because it is critical to state and federal programs designed to improve access to healthcare services. VDH presently has only one FTE overseeing the designation process, whose time is frequently also pulled for other essential activities. The designation process becomes central to improve access to quality healthcare and the supply of the healthcare workforce in underserved areas.

If the designation process is optimized it has the potential of bringing in millions of additional federal grant dollars. Of the $94,801,087 of financial assistance awarded by HRSA grants to Virginia in 2007, $27,053,234 (29 percent) were awarded for Community Health Center (CHC) development. In addition over one million dollars in HRSA Rural Network and Outreach Grants came into Virginia's rural underserved areas. Such awards can only be received in areas that have HPSA and/or MUA designations. In addition to federal grant funds, receiving HPSA and MUA designations also significantly enhances reimbursements for both Medicaid and Medicare for physicians in underserved areas. Primary Care and Mental Health HPSA providers receive a ten percent incentive bonus payment on all Medicare clinical services from the Centers for Medicaid and Medicare Services (CMS). Virginia practitioners in HPSAs received approximately $3 million in extra reimbursements in 2006 from this program. In rural areas primary care services in HPSAs and geographic MUAs can also be reimbursed at cost (rather than fee-for-service) within the CMS certified Rural Health Clinics program. Virginia has 50 rural health clinics. These enhanced reimbursement programs support the Commonwealth's physician retention efforts in underserved areas. In addition to the designation of geographical areas and areas with low-income populations, state facilities, such as the Commonwealth's correctional and mental health facilities, as well as Community Services Boards' (CSBs) catchment areas, can be designated in support of their recruitment and retention programs.

- *The Governor should provide funding to the Office of Minority Health and Public Health Policy (OMHPHP) for increased staff support for designations of Federal Health Professional Shortage Areas (HPSAs), Federal Medically Underserved Areas (MUAs), and Medically Underserved Populations (MUPs).*

Recommendations to increase physician educational capacity

A. As noted above, the Commonwealth is not producing enough physicians to eliminate the gap between supply and demand. At a time when there is a need for more physicians, this is unacceptable. To address this discrepancy, it is essential to use facilities planning and program development to evaluate current physician educational capacity. These plans should then be used to make strategic decisions to expand this capacity.

- *The Governor should require all University Presidents to submit strategic plans, with cost implications, that identify enrollment capabilities and resource requirements to increase medical school class size.*

B. To increase educational capacity, funding is absolutely necessary. This funding can come from outside sources, but as the state has a serious stake in the production of physicians, the Commonwealth should provide funding for to cover increased teaching time for faculty, which will be required to teach a larger number of physicians.

- *The Governor should provide funding to cover increased faculty teaching time due to any increases in class size that take place.*

C. In addition to providing additional funding to increase the educational capacity of medical schools in Virginia, it is also imperative to incent innovation to change the educational model. There are many creative solutions that schools can employ to enhance the preparation of medical students as well as increase the number of physicians trained and graduated in a year. To do this, schools should apply for grant funding provided by the state. Schools would need to demonstrate, in their application, how the changes they would make to the current educational model with the funding provided would produce additional and higher quality physicians.

- *The Governor should provide grant funding to medical schools for implementing innovative practices that will change the medical educational model to produce additional and higher quality physicians.*

D. Increasing physician productivity through the use of physician extenders would complement the increases to medical school education capacity. The Commonwealth has typically been stringent in its use of physician extenders. With a physician shortage looming, it is time for the Commonwealth to be more creative and look at how this segment of the workforce can help enhance and extend the physician workforce.

Currently, there are nine nurse practitioner programs operating in Virginia at the University level. There are ten specialty categories of nurse practitioners in Virginia jointly licensed and regulated by the Boards of Nursing and Medicine. Virginia is one of only 4 states in the country that requires joint licensure. Data from National Council of State Boards of Nursing indicates in 2007 for nurse practitioners, 29 states have collaborative practice, while 20 states have independent practice. The trend nationally is toward independent practice for nurse practitioners; in 2003, only 6 states reported independent practice for nurse practitioners.

In Virginia, nurse practitioners who are registered nurses with a graduate degree from an approved nurse practitioner education program and hold a national specialty certification as a nurse practitioner must practice in collaboration with and under the medical direction and supervision of a physician. Nurse practitioners are authorized to prescribe Schedules II – VI drugs in accordance with a practice agreement jointly developed by the supervising physicians and the nurse practitioner that describes and directs the prescriptive authority of the nurse practitioner. With very few exceptions, a separate office may not be established for a nurse practitioner because of the requirement for the supervising physician to practice in the same location as the nurse practitioner.

Currently there are four physician assistant programs in Virginia at the University level. Physician assistants practicing in the Commonwealth are required to be licensed by the Virginia Board of Medicine and must practice under the supervision of a licensed physician. The parameters of practice for the physician assistant are required to be documented in a practice protocol by the supervising physician and the physician assistant. Physician assistants are not licensed by specialty in the Commonwealth, but the Board of Medicine regulations governing the supervising physician-physician assistant relationship require that the physician assistant practice within the scope of practice and proficiency of the supervising physician. Unlike nurse practitioners, who are trained in advanced nursing, PAs receive education specifically in the practice of medicine.

During his/her practice, the physician assistant is required to be under continuous supervision, however the requirement for continuous supervision does not anticipate that the supervising physician need be physically present in all locations at all times for

supervision. The practice protocol defines the supervisory relationship and must take into account the relevant scope of practice, the delegated medical tasks, the physician assistant's competency, the parameters of supervision/communication and a process by which the physician assistant's performance is to be evaluated. PAs can prescribe medications in all 50 states as well as D.C., Guam, and the U.S. Virgin Islands. As of July 1, 2007, physician assistants are authorized by the Code of Virginia to write Schedule II-VI controlled substances. To do so, the physician assistant must apply to the Drug Enforcement Administration for the authority to expand his/her prescriptive authority for controlled substances.

- *The Governor should increase physician productivity in the Commonwealth by*
  a. Increasing the number of physician extender programs across the Commonwealth, and
  b. Examining and expanding the scope of practice of physician extenders.

Recommendations for the private sector

A. Presently, the Commonwealth has medical malpractice caps in place that provide physicians with some protection from the ever increasing amount needed to cover malpractice insurance. Maintaining a malpractice cap is a priority for the Medical Society of Virginia (MSV). The law concerning the cap comes up for review in 2008. Arguably, a cap makes a state more attractive in which to practice. It helps keep malpractice premiums down, thereby decreasing overhead for practicing physicians. These caps should be maintained so that Virginia will continue to be an attractive state for physicians to settle in.

- *The Governor should ensure that the medical malpractice caps currently in place remain.*

B. Electronic health records (EHR) have been touted with having the potential to increase physician productivity, thereby extending the physician workforce. The Commonwealth has made some investments in trying to increase take up of EHR systems through grants the Health IT Council is charged with awarding. The funds that have been put forward for these grants have been modest. In addition, the concept of having a help desk that would help physician offices navigate and determine which type of system they should use would be very valuable. Physician offices often do not have the time or expertise to know which system is best for them. The state should work to offer guidance on those systems that provide a high quality product and have interoperability as a key component.

- *The Governor should incent EHR adoption through grants and a help desk concept.*

ESTIMATED COSTS

Table 6: Pricing of Physician Workforce Recommendations (Annual Estimated Costs)

1A. The Governor should increase the retention rates of both medical students and residents through: a. Provide funding to the Office of Minority Health and Public Health Policy (OMHPHP) to increase staffing so that OMHPHP can more aggressively market Virginia programs and the state as an option b. Increase funding for existing scholarship and loan repayment programs c. Increase the number of GME slots and salaries for residents	$ 2,864,377
1B. Provide funding for increased staff support for designations of Federal Health Professional Shortage Areas (HPSAs), Federal Medically Underserved Areas	$ 176,623

(MUAs), and Medically Underserved Populations (MUPs)

2A. Require all University Presidents submit strategic plans, with cost implications, that identify enrollment capabilities and resource requirements to increase medical school class size	$	0
2B. Provide funding to cover increased teaching time	$	2,500,000
2C. Provide grant funding to medical schools for implementing innovative practices that will change the medical educational model to produce additional and higher quality physicians	$	10,000,000
2D. Increase physician productivity through use of physician extenders	$	1,000,000
3A Maintain medical malpractice caps	$	0
3B. Incent EHR adoption through grants and help desk concept	$	1,000,000
Total	**$**	**17,541,000**

BACKGROUND – NURSING WORKFORCE

National Nursing Shortage

The current demand for full-time-equivalent (FTE) Registered Nurses (RNs) in the United States significantly exceeds the available supply. Over the past decade; demand has grown at a greater rate than the supply, and over time there will be a considerable nursing shortage in the nation. The following table demonstrates the projected RN demand for the United States from 2000 until 2020. In a recent study, it was projected that by 2020 the national US RN shortage would equal 340,000 RNs. This is significantly less than earlier projections for a shortfall of 800,000 RNs, which was made back in 2000. Despite that the shortfall is projected to have decreased, the nursing shortage is still expected to increase three times the current rate over the next thirteen years. Policy, legislation, and budgetary changes will be necessary to help ease the burden of any shortfall.[57]

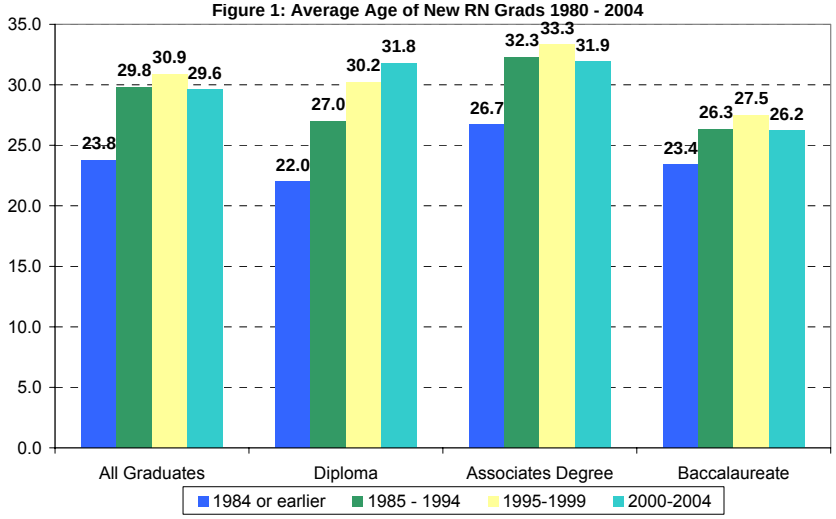
Table 1: Projected RN Demand – United States (FTE) [58]

Projected FTE RN Demand			Projected Growth	
2000	2010	2020	2000 to 2010	2000 to 2020
2,001,000	2,346,000	2,822,000	17%	41%

Data Source: NDM projections, National Center for Health Workforce Analysis, BHPr, HRSA.

The average age of the RN population in March 2004 was 46.8 years of age, up from 40 in 1980. The RN population under the age of 30 dropped from 9.0 percent of the nursing population in 2000 to 8.0 percent in 2004. Compared to 1985 where approximately 25 percent of nurses were under age 30, the nation has seen a sever aging of the nursing workforce. High levels of retirements are projected in the next ten to fifteen years as nurses enter their sixties. This aging of the workforce is coupled with the fact that the average age of nursing students is increasing as well as the average age of first-time licensed nurses. This not only indicates fewer productive work years will be garnered from the new RN graduates, it also indicates that the average age of nurses is likely to continue to increase over time.[59]

Figure 1: Average Age of New RN Grads 1980 - 2004



Source: HRSA, BHPr, DoN NSSRN 2004

With improved technology and managed-care, patients requiring a hospital stay typically have a higher acuity than what was previously seen. These sicker patients require intense treatment increasing the demand for skilled and specialized nurses. An adequate supply of nurses is essential to provide quality healthcare for consumers. As our nation's population continues to age and increase in size, the importance and utilization of the healthcare system will become more prevalent. For the United States to maintain its global position as a world power, American citizens must stay healthy and remain productive

[57] Auerbach, D. I. (January/February 2007). *Better Late than Never: Workforce Supply Implications of Late Entry into Nursing*. Health Affairs.

[58] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

[59] American Association of Colleges of Nurses. *Fact Sheet: Nursing Shortage*. Retrieved July 27, 2007, from: http://www.aacn.nche.edu/Media/FactSheets/NursingShortage.htm.

members of society. It is imperative to have an adequate supply of nurses, so America can continue to progress in the twenty-first century.[60]

Virginia Nursing Shortage

Nurses play a critical role within the healthcare community. Meeting the existing and future demands for nurses is vital to the stability of Virginia's healthcare system. The shortage of registered nurses and other allied health professionals in Virginia is a critical workforce issue that the Commonwealth must continue to address and emphasize through policy, legislation, and budgetary decisions. Key findings of SCHEV's 2004 report, *Condition of Nursing and Nursing Education in the Commonwealth*, indicate that:

1. The demand for nursing services in the Commonwealth is growing. General population growth, an increase in Virginia's aging population, and trends in healthcare services utilization are major causes for the increasing demand for qualified nurses.

2. The supply of RNs will become inadequate as demand continues to grow. Additional nurses are needed to meet this demand and to replace those nearing retirement.

3. Numerous nursing education programs are located in Virginia, but serious limits exist in the number of applicants that can be accepted. Any expansion of nursing education programs is dependant on having an adequate number of and well-prepared nursing faculty.

As the segment of Virginia's population above age 65 increases, so does the demand for qualified nurses. At the same time, factors both within and outside the healthcare profession have rendered increasing the supply of nurses and nursing faculty difficult. Combined, these conditions have left Virginia with a nursing shortage that is anticipated to escalate. Although the RN shortage is a national problem, Virginia's projected supply shortage is slightly higher than the national average based on the growing demand for medical care. The following table demonstrates the projected RN demand for Virginia from 2000 to 2020.

Table 2: Projected RN Demand – Virginia (FTE)[61]

Projected FTE RN Demand			Projected Growth	
2000	**2010**	**2020**	**2000 to 2010**	**2000 to 2020**
49,200	59,100	69,600	22%	42%

Data Source: Projections from National Center for Health Workforce Analysis Nursing Demand Model adapted for Virginia

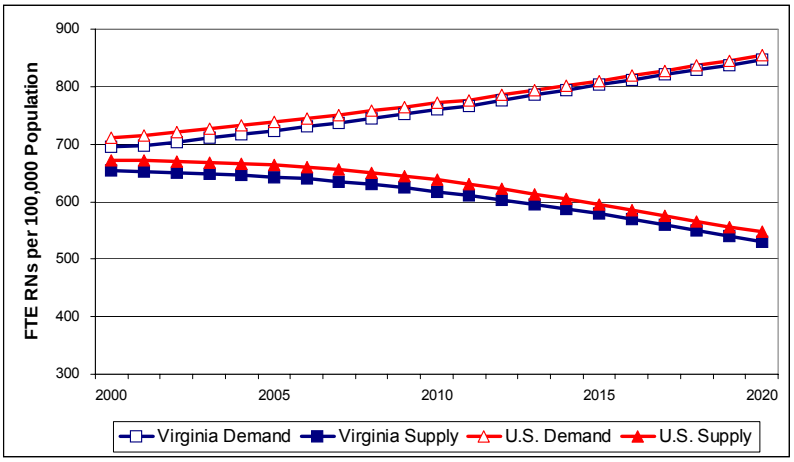
The demand for FTE RNs in Virginia is expected to increase by roughly 43 percent between 2000 and 2020. The supply of FTE RNs in Virginia is anticipated to be 47,000 by 2020; however, demand is expected to exceed 69,600. This is a shortfall of 22,600 or 32.6 percent. To meet this demand it is expected that RN supply will have to increase by 60 percent. As seen in Figure 2 below, Virginia is projected to have a significant shortage of nurses, one that mirrors the US shortage.[62]

[60] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

[61] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

[62] Maddox, P.J. (2007). *Today is the 'Good 'Ole Days': Virginia's RN Workforce Trends.* George Mason University: Fairfax, VA.

Figure 2: Projected RN Shortage – Comparison of the US and Virginia[63]



Data Source: National Center for Health Workforce Analysis, BHPr, HRSA

Several demographic factors contribute to the shortage of nurses in Virginia including the projected population growth and growing elderly population. According to the U.S. Census Bureau, Virginia's population increased 14 percent between 1990 and 2000. This population growth is anticipated to grow by an additional 12 percent by 2010. From 1990 to 2000, the average age of Virginians rose from 32 to 35, and this trend will continue as the 'baby boomer' generation continues to age. The age composition of Virginia's population is projected to change substantially by 2020. The largest growing population is the elderly, aged 65 and above; similarly, the next largest growing age group is the near elderly, aged 45 to 64. The number of Virginians aged 65 and older will grow by 30 percent between 2000 and 2020. Because the largest cohort of Virginians is the baby boomers, aged 45 to 54, the median age will continue to rise. Baby boomers will enter into the 65-and-older age group by 2010. The elderly population utilizes a significant amount of hospital resources. Those aged 65 and older only represent 11 percent of the population in the Commonwealth, but consume roughly 35 percent of hospital resources.[64]

The supply of FTE nurses in the workforce is significantly less than the number of licensed RNs, because not all licensed RNs are full time employees or participate in the workforce. There are many RNs that work on a part time basis or strictly provide in-home services to their family. The Virginia Board of Nursing estimated that in May of 2001 there were close to 66,000 RNs licensed in Virginia. The 2000 National Sample Survey of RNs indicated that there were approximately 45,000 FTE RNs working in Virginia, so the FTE supply of working nurses approximates 70 percent of total licensed RNs. This estimate is similar to the national ratio of RNs to FTE RNs.[65]

The average age of an RN in Virginia is over 45. The population of RNs currently 45 years of age is expected to begin retiring as they enter their sixties. Over the next 10 to 15 years, baby boomers will leave the workforce and become part of the population that will utilize health services at an increasing rate. The FTE supply of RNs is projected to slowly increase from approximately 2010 to 2015, at which time the number of RNs withdrawing from the workforce (either retiring or deciding not to practice full-time in nursing) will exceed the number of new RN graduates. This will lead to a gradual decrease in supply of FTE RNs.[66]

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[63] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

[64] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

[65] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

[66] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

In SCHEV's 2004 report, *Condition of Nursing and Nursing Education in the Commonwealth,* three different scenarios were created to address the nursing shortage. Scenario 1 doubles the annual number of graduates for all nursing programs. This scenario assumes that nursing education capacity will increase gradually over a period of six years. In this scenario, FTE RN supply increases to 50,300 in 2010 and to 60,400 in 2020. Scenario 2 doubles the annual number of graduates in the regions with the fastest growing demand for RNs (i.e., Central, Hampton Roads, and Northern Virginia). This scenario assumes a 25 percent increase in the annual number of graduates in all three regions. In this scenario, FTE RN supply will increase to 49,200 in 2010 and to 55,300 in 2020. Finally, Scenario 3 assumes 50 percent increase in the annual number of graduates from all programs. In this scenario, FTE RN supplies increase to 49,015 in 2010 and to 52,663 in 2020.[67]

Since the above scenarios are over three years old, the Workgroup decided to use the least aggressive scenario as a starting point. While this scenario will not completely close the gap between supply and demand of nurses, it is the scenario the Workgroup felt was most appropriate and achievable over the next thirteen years. This scenario would require the Commonwealth to produce an additional 900 nurses per year.

Virginia's Educational Capacity

The disparity between the healthcare needs of Virginians and the current supply of RNs is not only a result of the growth in population and aging Virginians, but is also a product of multiple factors related to educational capacity. These issues primarily include an insufficient number of faculty and clinical training sites for RNs. The shortfall in the supply of RNs can partially be attributed to the lack of resources needed to properly educate the nursing workforce in the Commonwealth.[68]

Nursing education programs are geographically well distributed throughout the Commonwealth, providing Virginians with easier access to these programs (See Appendix E for additional information). At any one time, over 6,000 students are enrolled in Virginia's nursing education programs. Not only is there a shortfall between the RN demand and the RN supply, but due to the shortage in educators and facilities, there is also a shortfall between the number of students Virginia Nursing Programs can currently educate each year and the level of interest in pursuing a career as an RN. This is particularly unfortunate given the high number of qualified applicants denied admission to nursing programs due to program capacity limitations. In 2003, programs throughout the Commonwealth had to turn away more than 1,300 qualified applicants. This problem persists today, and the number of qualified applicants being turned down continues to grow both across the country and in Virginia.[69]

Table 3: Distribution of Nursing Schools and Students by Degree Program, Combined AACN/GMU Survey Results for Academic Year 2001 – 2002[70]

Region Name	Basic Degree Programs				Advanced Degree Programs		
	Schools	Enrollment	Graduated	Rejected	Enrollment	Graduated	Rejected
Blue Ridge	8	988	360	107	419	230	0
Central	5	1,199	390	124	720	138	21
Hampton Roads	8	1,208	437	307	692	214	0
Northern Virginia	3	1,202	430	280	1,022	289	240
Roanoke	8	926	322	16	116	18	0
Southwestern	4	515	198	563	0	0	0
Total	**36**	**6,038**	**2,137**	**1,397**	**2,969**	**889**	**261**

NOTE: The reported numbers may not represent an unduplicated count due to the reliance upon available administrative data. For example, individuals might both apply and be rejected from more than one school.

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[67] Virginia Hospital and Healthcare Association. (April 2004). *Where We Stand Projected Nurse Demand and Supply in Virginia, 2000 – 2020*. Richmond, VA.

[68] Health Reform Commission. (November 2006). *The Nursing Shortage: Workforce Subcommittee Meeting*. Richmond, VA.

[69] Health Reform Commission. (November 2006). *The Nursing Shortage: Workforce Subcommittee Meeting*. Richmond, VA.

[70] Health Reform Commission. (November 2006). *The Nursing Shortage: Workforce Subcommittee Meeting*. Richmond, VA.

It is difficult to recruit, hire, and retain nursing faculty because salaries are $10,000 to $15,000 below the competitive range. Nursing programs in Virginia report significant difficulty in filling nursing faculty vacancies as well as in hiring senior-level faculty members, largely due in part to low salary levels. Presently, nurses in the private sector are often paid higher wages than faculty. This coupled with the cost of going back to school can make the practice of teaching unattractive to many nurses.[71]

Nursing programs in Virginia are extremely expensive to operate relative to current tuition and fee revenue. In order to be an accredited program by the Board of Nursing, nursing programs must maintain a low faculty-to-student ratio of 1:10 to assure the safety of patients during clinical training courses. Because of the changing dynamic in the U.S. and Virginia's healthcare systems, there is an ever increasing demand for nurses with advanced education and degrees.[72]

Just as with nurses in the private sector, the average age of nursing faculty has been increasing over time. In 2002, the average age of nursing faculty in Virginia was 53, significantly higher than the average of an RN in Virginia, 45. The loss of nursing faculty to age-related retirement will significantly and adversely impact Virginia's nursing workforce by 2020. Without replacement faculty for those who will be retiring and without an interest from nurses in the field to go back to school and train to be faculty, Virginia will continue to have to turn away qualified applicants and the nursing shortage will be felt strongly throughout the Commonwealth.[73]

WHY PURSUE POLICY CHANGE

Research indicates that there is a positive correlation between the quantity of available and competent RNs and the cost, quality, and access of healthcare related services for the citizens. Nurses have a strong presence within the healthcare community, with more than four times as many RNs in the United States as physicians.[74] An inadequate supply of nurses puts patient safety at risk, causes access to care to become compromised, and increases the costs associated with health services.[75] In a time where access to quality care is at the forefront of the Nation's healthcare crisis, an adequate supply of nurses is a must. For Virginia to ensure this adequate supply, policy change is necessary.

A basic component of Virginia's infrastructure imperative for regional economic growth is a sound healthcare system. Without an adequate supply of nurses, Virginia's future is in jeopardy. Healthcare providers contribute significantly to regional economic conditions as employers. Health facilities have a greater likelihood of reduced revenues and an increased risk of closing when they are short staffed. When these facilities are not adequately supplied, employees are not capable of providing sufficient access and quality health services within their communities. The nursing shortage not only has implications for the quality of healthcare provided to Virginias, but also affects the Commonwealth's ability to attract and retain employers. As the disparity between nursing workforce demand and supply continues to grow, the associated financial risks to the Commonwealth will become more and more apparent.[76]

[71] Health Reform Commission. (November 2006). *The Nursing Shortage: Workforce Subcommittee Meeting*. Richmond, VA.

[72] Health Reform Commission. (November 2006). *The Nursing Shortage: Workforce Subcommittee Meeting*. Richmond, VA.

[73] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

[74] American Association of Colleges of Nurses. (March 2004). *Your Nursing Career: Look at the Facts*. Retrieved July 27, 2007, from: http://www.aacn.nche.edu/Education/career.htm.

[75] Aiken, L.H. & Fagin, C.M. (1997). Evaluating the Consequences of Hospital Restructuring. *Med Care,* 35 (10 Suppl). OS1-4.

[76] State Council on Higher Education for Virginia. (January 2004). *Condition of Nursing and Nursing Education in the Commonwealth.* Richmond, VA.

RECOMMENDATIONS

The Workforce Workgroup of the Health Reform Commission (Commission) developed several recommendations concerning the Nursing Workforce in the Commonwealth. Both the Workforce Workgroup and Commission had to narrow the number of recommendations to those that were felt to be of most importance. These recommendations can be broken down into what should be done for nursing educational capacity, faculty retention and development, and the private sector. For a listing of all of the recommendations that were evaluated, please see Appendix F.

Recommendations to increase nursing educational capacity

A. As noted above, the Commonwealth is turning away qualified nursing applicants yearly. At a time when there is a need for more nurses, this is unacceptable. To address this discrepancy, it is essential to use facilities planning and program development to evaluate current nursing educational capacity. These plans should then be used to make strategic decisions to expand this capacity.

- *The Governor should require all University Presidents and the Chancellor of the Virginia Community College System to submit strategic plans, with cost implications, that identify enrollment capabilities and resource requirements to increase basic nursing programs (pre-licensure) by 50 percent and 100 percent. Based on the strategic plans developed:*
  1. *Existing bachelor's and associate degree programs should be expanded to allocate the additional 900 nursing students per year necessary to begin closing the gap between supply and demand.*
  2. *Accelerated nursing school programs for students with degrees in other fields should be expanded.*

B. As the acuity of patients and average age of the population continues to increase, so does the demand for skilled and specialized nurses. In addition, as the Commonwealth continues to experience a faculty shortage, more masters and doctoral prepared nurses will be required.

- *The Governor should provide funding to expand current and new masters programs.*

C. To increase educational capacity funding is absolutely necessary. This funding can come from outside sources, but as the state has a serious stake in the production of nurses, the Commonwealth should provide funding for educational capacity increase.

- *The Governor should provide funding for educational capacity increase through:*
  1. *Increased General Fund appropriations and block grants*
  2. *Formula funding systems to allocate appropriated funds*

D. In addition to providing additional funding to increase the educational capacity of nursing schools in Virginia, it is also imperative to incent innovation to change the educational model. There are many creative solutions that schools can employ to enhance the preparation of nursing students as well as increase the number of nurses trained and graduated in a year. To do this, schools should apply for grant funding provided by the state. Schools would need to demonstrate, in their application, how the changes they would make to the current educational model with the funding provided would produce additional and higher quality nurses.

- *The Governor should provide grant funding to nursing schools for implementing innovative practices that will change the nursing educational model to produce additional and higher quality nurses.*

Recommendations for faculty retention and development

A. Numerous strategies can be employed to improve recruitment and retention of faculty. Currently, retired state employees who are nurses cannot come back into the workforce and continue receiving their retirement. This impedes many nurses who would willingly come back to work part-time or full-time in both clinical and faculty settings. While there is a nursing shortage in the Commonwealth, the Commonwealth should tap into this already existing and qualified labor pool. There is no lag time for this labor pool to begin working. The barriers that prevent this labor pool from being used can easily be overcome through legislation.

- *The Governor should develop legislation that removes barriers for retired state employee nurses so that they may reenter the workforce while collecting retirement.*

B. To increase the number of nursing faculty in the Commonwealth, more nurses need to go back to school to receive their masters and/or PhD. A masters is the minimum requirement to teach at all levels, diploma, associates degree, and baccalaureate. Most Universities prefer to have PhD faculty. Going back to school for additional education requires both time and money. To make it more affordable for nurses to go back to school additional funding should be provided to existing scholarship and loan repayment/assistance programs.

- *The Governor should increase the number of doctoral and masters level students, who are focused on becoming educators, through increased funding to existing scholarship and loan repayment/assistance programs that have service requirements requiring teaching in the Commonwealth.*

Recommendations for the private sector

A. The state can create various incentives in the reimbursement system it controls, Medicaid. Using increased payments that are based on quality indicators (pay-for-performance) is one way to direct additional monies to providers. Through these incentives the Commonwealth should hope to see increased quality patient care for all patients.

- *The Governor through the Department of Medical Assistance services should modify reimbursement methodologies to the direct reimbursement of nursing care. This would include:*
  1. *Studying a Pay-For-Performance program that uses nurse sensitive indicators to pay hospitals and implement if appropriate.*

ESTIMATED COSTS

Table 4: Pricing of Nursing Workforce Recommendations (Annual Estimated Costs)

1A. Require all University Presidents and the Chancellor of the Virginia Community College System to submit strategic plans, with cost implications, that identify enrollment capabilities and resource requirements to increase basic nursing programs (pre-licensure) by 50 percent and 100 percent.	$	0
1B. Provide funding to expand current and new masters programs	$	5,000,000

1C. Provide funding for educational capacity increase through: c. Increased general fund appropriations and block grants d. Formula funding systems to allocate appropriated funds	$ 10,000,000
1D. Provide grant funding to nursing schools for implementing innovative practices that will change the nursing educational model to produce additional and higher quality nurses	$ 2,000,000
2A. Develop legislation that removes barriers for retired state employee nurses so that they may reenter the workforce while collecting retirement	$ 0
2B. Increase the number of doctoral and masters level students, who are focused on becoming educators, through increased funding to existing scholarship and loan repayment/assistance programs that have service requirements requiring teaching in the Commonwealth	$ 500,000
3A. Modify reimbursement methodologies to the direct reimbursement of nursing care. This would include: b. Studying a Pay-For-Performance program that uses nurse sensitive indicators to pay hospitals and implement if appropriate.	$ 0
Total	**$ 17,500,000**

BACKGROUND – DIRECT SUPPORT PROFESSIONALS

Definition – Who are Direct Support Professionals and what do they do

Direct Support Professionals (DSPs) take on many different roles and provide care to a wide range of people. The Workforce Workgroup decided that using the term direct support professionals truly encompassed the tough, demanding, challenging, and varied work these professionals take on. Included under this heading are the following job titles: certified nurse aides, orderlies, attendants, home health aides, personal care aides, home care aides, personal care attendants, psychiatric aides, direct care workers, direct services associates, paraprofessionals, medication aides, and community health workers.

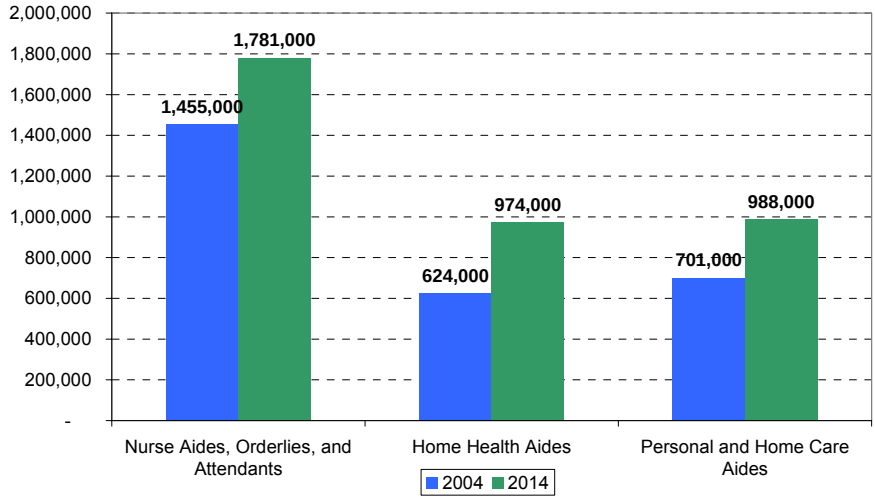
This segment of the workforce attends to the elderly, disabled, and others in long-term care settings. They work in hospitals, nursing homes, residential and assisted living facilities, adult day cares, people's homes, home health agencies, and other long-term care settings. They provide a significant amount of the care received by clients in long-term care settings and/or with long-term care needs. This care includes both physical care and emotional support and companionship. This workforce is often times the lifeline for their clients and is often the reason their client does not require institutionalization.

National Direct Support Professional Shortage

As has been noted above in the physician and nursing workforce sections the country's population is aging. In fact, those who are 85+ will be the fastest growing segment of the population until 2050. In addition, there are millions of Americans below the age of 65 who have some type of permanent or long lasting disability. In the Supreme Court's 1999 Olmstead decision, states are required to offer community based services as an option. There is expected to be a significant increase in the need for direct support professionals due to the aging of the population and the growing number of Americans with disabilities. People who need long-term care services often have at least one chronic disease and require help with activities of daily living, including bathing, dressing, and shopping for groceries.[77] As people migrate out of institutions and/or have more options available to them to stay in the community it will become imperative to have a workforce that is mobile, flexible, and plentiful.

Between 2004 and 2010 it is projected that number of jobs available in the long-term care sector will increase by 45 percent. This is significantly higher than the increase in total U.S. employment of 15 percent and even outpaces the increase in registered nurses and licensed practical nurses.[78] While there is expected to be tremendous growth in the number of jobs available, clients and providers currently face many challenges including high vacancy and turnover rates. Vacancies create significant problems for clients, who often go without the needed support until a worker can be found. In addition, high vacancy rates are challenging for providers who often have to use contract labor to fill positions and may have a difficult

Figure 1: Projected Growth in Direct Support Professional Jobs, 2004 - 2014



Source: U.S. Bureau of Labor Statistics May 2005

[77] U.S. Department of Health and Human Services. *A Profile of Older Americans: 2002.* Washington, D.C.

[78] Pohlmann, L. (February 2003). *Without Care: Maine's Direct Care Worker Shortage.* Maine.

time recruiting people into these roles. Turnover rates are challenging in that they can disrupt a client's care and can cost providers a significant amount of money in training, orientation, education, etc.[79]

Various issues negatively impact the direct support professional workforce and the recruitment of people into this field. This is a segment of the healthcare workforce that has low wages, limited access to health insurance, limited access to paid-time off, vacation days, and/or sick days, and a challenging work environment.[80] Across the country the average wage rate for these workers is $8.21, which is not significantly different from the federal minimum wage.[81] Between 1999 and 2002 the average wage rate increased by 9.2 percent. While this is a positive trend, the base wages are so low for people in this profession that it does not retain or recruit more people into the workforce.[82] In addition, employers of direct support professionals are often competing with the retail sector. Retail employers offer comparable wages and have a less stressful and arduous work environment. Finally, this workforce is often considered a secondary labor market that requires little skill. Unfortunately, this profession is not one to which people aspire to and policy makers and educators have historically not spent time focusing on the needs of this workforce and its clients.[83]

Table 1: National Wage Data for Direct Support Professionals, 2003[84]

Job Category	Median Hourly Wage
Nurse Aides, Orderlies, and Attendants	$9.80
Home Health Aides	$8.85
Personal and Home Care Aides	$8.19

The work environment for direct support professionals is extremely challenging. This segment of the workforce deals with cleaning, bathing, dressing, feeding, cooking, administering medications, lifting clients, and rehabilitation, among other things. This creates an environment that has a high risk of injury. In fact, there are so many injuries among this workforce — nursing aides alone average 200,0000 work related injuries per year — that they outpace coal mining and construction.[85] Aside from the physical demands of the work, there are equally challenging emotional demands. DSPs provide emotional support and companionship to their clients. This too can take a toll, specifically when a client passes away and the DSP is expected to move on to the next client.

Virginia Shortage

Like the nation, Virginia is experiencing an aging of its population. In fact, Virginia's elderly population is growing at an increased rate relative to the rest of the nation.[86] In 2000, 792,333 or 11.2 percent of Virginia's population were aged 65+, a 19.2 percent increase since 1990. The U.S. Census estimates that by 2030 Virginia's elder population will increase 132.7 percent. During this same time the traditional

[79] Centers for Medicare and Medicaid Services. (December 2006). *Promising Practices in Marketing, Recruitment, and Selection Interventions*. Direct Service Workforce Demonstration. Washington, D.C.

[80] National Governors Association. (January 2004). *Rescuing the Healthcare Workforce: Options for State Action.* Center for Best Practices. Washington, D.C.

[81] National Governors Association. (January 2004). *Rescuing the Healthcare Workforce: Options for State Action.* Center for Best Practices. Washington, D.C.

[82] The National Clearinghouse on the Direct Care Workforce. (September 2005). *Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce.*

[83] Centers for Medicare and Medicaid Services. (December 2006). *Promising Practices in Marketing, Recruitment, and Selection Interventions*. Direct Service Workforce Demonstration. Washington, D.C

[84] The National Clearinghouse on the Direct Care Workforce (September 2005). *Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce.*

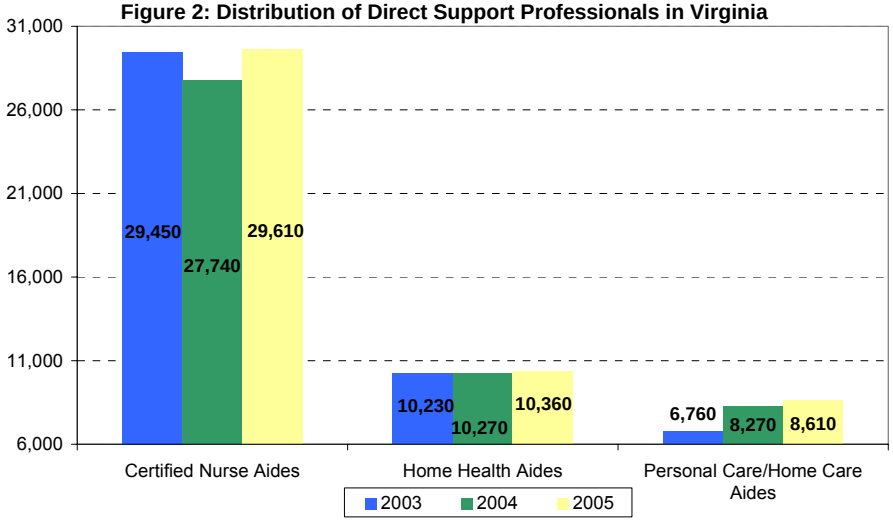
[85] Dawson, S. and Rick, S. *Direct-Care Health Workers: The Unnecessary Crisis in Long-Term Care.* Washington, D.C.

[86] Center for Workforce Studies. (2006). *Key Physician Data by State with Virginia Highlights*. Association of American Medical Colleges.

care giving workforce, women aged 25 to 44, is only expected to increase 15.9 percent.[87] Based on population demographics alone, the Commonwealth must act now in order to increase the supply of this workforce and must work to recruit different individuals, particularly those from non-traditional labor pools.

Virginia's long-term care support system includes a network of institutions, federal and state funded community programs administered through various agencies, and over two hundred home health service providers. According to a survey by the American Healthcare Association in 2002, the statewide vacancy rate for Virginia certified nurse aides, was 8.2 percent, and the turnover rate was 73.2 percent. It is expected that these numbers will continue to worsen as the population ages.[88] Figure 2, shows the distribution of some segments of the direct support professional workforce for Virginia. These numbers have been fluctuating and showing very little growth. Coupling this with the turnover and vacancy rates, the 'care gap' between those needing care and those available to care will widen.

Figure 2: Distribution of Direct Support Professionals in Virginia



Source: US Bureau of Labor Statistics, 2005

Wages for direct support professionals in Virginia are lower than the national average. In 2005, Virginia was in the bottom ten states for hourly wage, ranked 44th for personal and home care aides.[89]

Table 2: Virginia Wage Data for Direct Support Professionals, 2003[90]

Job Category	Median Hourly Wage
Nurse Aides, Orderlies, and Attendants	$9.19
Home Health Aides	$8.46
Personal and Home Care Aides	$7.07
Weighted Median Hourly Wage	$8.72

The Virginia Employment Commission (VEC) anticipates 19,211 new DSP positions will be created by 2014, a 38 percent increase over the number of positions held in 2004. In Virginia, the projected growth in positions between 2004 and 2014 for home health aides is 62 percent, for personal and home care

[87] 2000,Census Brief. (2000). Retrieved July 25, 2007, from: www.census.gov.

[88] American Healthcare Association. (2003). *Survey of Nursing Staff Vacancy and Turnover in Nursing Homes*. Retrieved July 20, 2007, from: http://www.ahca.org/index.html. Washington, D.C.

[89] U.S. Bureau of Labor Statistics. (May 2005). *Occupational Employment Statistics May 2005*. Washington, DC.

[90] The National Clearinghouse on the Direct Care Workforce. (September 2005). *Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce.*

aides 41 percent, and for nurse aides, orderlies, and attendants 26 percent.[91] This phenomenal growth in positions begs that something is done now in order to ensure an adequate supply.

Data Gaps in Virginia

Of the three workforce areas reviewed at by the Workforce Workgroup, the direct support professional area was lacking the most data making it difficult to decide which recommendations should be put forward. Therefore, the Workforce Workgroup believes that the Workforce Data Center discussed in the Introduction to the Healthcare Workforce is particularly essential for direct support professionals. Presently, the following data points are unclear for this segment of the healthcare workforce:

- Current and projected numbers of persons with disabilities needing long-term by service setting
- Demographics of the direct support professional workforce
- Estimated demand for workers by setting and occupation
- Availability of family caregivers (paid/unpaid)
- Types of employers and number
- If and how employers are changing

WHY PURSUE POLICY CHANGE

There are economic advantages to having a strong supply of direct support professionals. Shortages in the long-term care sector can have a substantial impact on healthcare costs. Direct support professionals are expensive to replace, costing approximately $2,341 (2004 dollars) to replace one direct support professional. In addition, when long-term employers do not have enough available staff, they often have to rely on contract labor, which can cost up to three times more than an employee. Using contract labor not only raises labor costs, but it can also cause morale issues among staff who know they are being paid significantly less and it can lead to quality issues due to lack of coordination and the constant churn of contract labor. As the shortage of workers in the long-term sector continues, healthcare costs will continue to escalate and providers will find it difficult to provide coordinated quality care.[92]

Another reason to pursue policy change is a result of the changing demographics and shift in consumer preferences. As has been noted, Virginia's elderly population is rapidly increasing. This segment of the population will require more long-term care services. This population will also expect and has the right to age in place, which will require more community based services. All of this indicates that a larger supply of direct support professionals will be needed. Finally, a shortage in this workforce will affect quality of care for clients. The Commonwealth must act now to ensure that the elderly and disabled have access to high quality services in the setting of their choosing.

RECOMMENDATIONS

The Workforce Workgroup of the Health Reform Commission (Commission) developed several recommendations concerning the direct support professional workforce in the Commonwealth. These recommendations are primarily centered on innovative strategies for outreach, recruitment, and retention of traditional and non-traditional labor pools. Both the Workforce Workgroup and Commission had to narrow the number of recommendations to those that were felt to be of most importance. For a listing of all of the recommendations that were evaluated, please see Appendix G.

- *Recommendations for direct support professionals*

    A. In 2003, the Centers for Medicare and Medicaid Services (CMS) launched the *Demonstration to Improve the Direct Service Community Workforce*. Five states were

[91] Virginia Employment Commission. Virginia Electronic Labor Market Access.

[92] National Governors Association. (January 2004). *Rescuing the Healthcare Workforce: Options for State Action.* Center for Best Practices. Washington, D.C.

awarded grants; Virginia was not one of these states. In 2004, five more states were awarded grant funding; this time, Virginia was one of the states. With this funding, the Department of Medical Assistance Services (DMAS) has collaborated with several local organizations to develop targeted recruitment and marketing materials designed to attract new people to the field of direct support. The marketing materials include brochures in English, Spanish, Farsi, and Korean. DMAS sub-contracted with the Northern Virginia Skill Source Center to hire a dedicated Job Developer to recruit people into the direct support career path. DMAS also collaborated with the Virginia Geriatric Education Center (VGC) at Virginia Commonwealth University to recruit and train family members and respite providers to enter the direct support field.

This program has been quite successful in Virginia and could be replicated in other areas of the state. The program requires at least one full time equivalent with a salary of approximately $45,000 per year plus benefits. In addition, the current Job Developer in Northern Virginia could be pulled from Northern Virginia to be the trainer and supervisor for the replicated pilots as long as the position in Northern Virginia is backfilled with a possibility of adding another person in Northern Virginia to better cover the region. All of the pilots could use the marketing and training materials that have already been created in the Northern Virginia demonstration. The pilots should cover all geographic areas of the state; therefore, five pilots in addition to Northern Virginia would be necessary—Southwest Virginia, Southside Virginia, Central Virginia, Hampton Roads, and West Central Virginia.

- *The Governor should replicate the Department of Medical Assistance's Demonstration to Improve the Direct Service Community Workforce in six pilot sites across the Commonwealth.*

B. Currently, the Commonwealth does not provide scholarships or loan repayment programs for direct support professionals. This segment of the healthcare workforce is the most likely of all the areas of the workforce to work more than one job and to be in one or multiple low-wage jobs. To incent more people to go back to school for training and who want to enter this profession, the Commonwealth should offer scholarships and loan repayment programs just as it does for nurses and physicians. These programs can and should have service requirements attached to them. These service requirements should be less than what is asked of for physicians and nurses because the dollar amount being provided is significantly smaller. A service requirement of a year would be reasonable. Finally, this would be of low cost to the state as most personal care attendant programs are $500 or less and most certified nurse aide programs are $1,600 or less.

- *The Governor should provide funding for scholarship and loan repayment programs for the direct support professional workforce that includes one year service requirements.*

C. Virginia has recently updated and reformed its Temporary Assistance for Needy Families (TANF) program to comply with new federal work requirements. These requirements will reduce the number of TANF work exemptions and Virginia's Department of Social Services will be required to place more TANF recipients in the workplace than ever before. Workforce Investment Boards (WIBs) administer federal Workforce Investment Act funds as well as state programs designed to assist localities with workforce investment strategies. The Department of Social Services, WIBs, and One Stops should be partnering to maximize their funding and to recruit more people into the direct support professional workforce. In addition, they should work with LTC providers and other organizations that recruit and train direct support professionals so that more TANF recipients can be placed in direct support professional training programs. Any initiatives in this area should be coupled with efforts to ensure participants have adequate access to child care during the program and once they become employed.

For partnering to take place, integration and coordination must be improved. This will require training of staff and a culture change. The Secretary of Health and Human Resources and the Governor's Senior Advisor on Workforce should work together to ensure this collaboration takes place in an appropriate and timely fashion. To not overwhelm the current system, this should be implemented through a few pilot programs that can test the best way to coordinate and use funding to accomplish the following:

a. Provide funding to increase TANF recipients entering the direct support professional workforce;
b. Develop direct support professional entry-level worker training programs and career ladders;
c. Implement cross-training programs for One-Stops and DSS staff;
d. Emphasize One-Stop System as part of the continuum of services for the TANF population;
e. Develop short-term intensive, integrated education and training programs to include an infusion of "soft skills" development; and
f. Use a person centered approach incorporating upfront assessments to determine needs and interagency collaborative case management to provide workforce and income supports.

Finally, it should be noted that while these pilots would begin with a focus on the TANF population, there is no reason this could not be expanded to other untapped labor pools including: people with disabilities, prisoners who are reentering society, etc.

- *The Governor should develop pilot programs to implement integration of Workforce Investment Boards, Social Services, and One Stops to place more TANF recipients in direct support professional roles.*

D. As noted above, this segment of the healthcare workforce is often considered a secondary labor market that requires little skill. This profession is not one to which people aspire to and policy makers and educators have historically not spent time focusing on the needs of this workforce. A social marketing campaign could begin to develop a positive image of direct support professionals. The campaign should focus on educating citizens of the Commonwealth what a direct support professional is, what direct support professionals do, the importance of this workforce as society ages and for the disabled, and why this is a good profession to work in.

- *The Governor should create a social marketing campaign that creates a positive image of direct support professionals and demonstrates the importance of this workforce.*

E. The Workforce Investment Boards (WIBs) should recognize that the shortage of direct support professionals is a statewide issue that requires particular attention and support. Therefore, the WIBs should be assigned to include the direct support professional workforce issue as a focus area.

- *The Governor should enable the WIBs, through legislation, to have a sector strategy for direct support professionals.*

ESTIMATED COSTS

Table 3: Pricing of Direct Support Professional Recommendations (Annual Estimated Costs)

1A. Replicate the Department of Medical Assistance's Demonstration to Improve the Direct Service Community Workforce in six pilot sites across the Commonwealth*	$	1,036,800
1B. Provide funding for scholarship and loan repayment programs for the direct	$	50,000

support professional workforce that includes one year service requirements		
1C. Develop pilot programs to implement integration of Workforce Investment Boards, Social Services, and One Stops to place more TANF recipients in direct support professional roles	$	1,000,000
1D. Create a social marketing campaign that creates a positive image of direct support professionals and demonstrates the importance of this workforce	$	1,000,000
1E. Enable the WIBs, through legislation, to have a sector strategy for direct support professionals	$	0
Total	**$**	**3,086,800**
*This funding would be for three years for the six pilots and would all be appropriated in year one		

INTRODUCTION TO ACCESS TO CARE

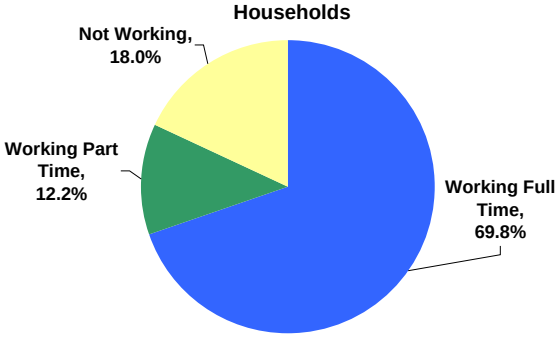
The Access to Care Workgroup held four sessions over six months to develop recommendations for consideration by the Health Reform Commission. The Workgroup relied heavily on the recent Joint Legislative Audit and Review Commission (JLARC) report, "Options to Extend Health Insurance Coverage to Virginia's Uninsured" and Virginia Healthcare Foundation's Urban Institute Report to identify critical areas for reform and develop priorities.[93,94] The Workgroup identified options within three market segments: (1) the healthcare safety net, (2) Medicaid and FAMIS, and (3) the private health insurance market. The Commonwealth must accelerate its efforts to expand access to quality care so all Virginians will be on the road to achieving the best possible healthcare.

BACKGROUND – ACCESS TO CARE

The Challenge of Virginia's Uninsured

More than 1.1 million Virginians—15.5 percent of residents—are uninsured.[95] One in five adults lack coverage compared to one in eleven children. While the vast majority of privately insured Virginians secure their coverage through their employers, there has been erosion of employer-based coverage during the past ten years. Thus, despite the relatively healthy economy in the Commonwealth, some striking statistics indicate the need to examine new ways to provide health coverage for the uninsured:

Figure 1: Percent of Non-Elderly Uninsured in Working Households



- Nearly 70 percent of the uninsured live in households with at least one full-time worker (Figure 1).[96]
- The self-employed and those working in firms with fewer than 100 employees account for the majority of uninsured.[97]
- Nearly three-quarters of uninsured Virginians report they live in households where there is no offer of employer-sponsored health insurance.[98]
- Nineteen to 34 year olds have the highest rate of un-insurance among non-elderly adults—nearly 27 percent do not have health insurance.[99]
- Uninsured rates are significantly higher for those living in poverty compared to those with incomes above 300 percent of the Federal Poverty Level (FPL) (Figure 2).[100]

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[93] Joint Legislative Audit and Review Commission. (January 2007). *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*. House Document No. 19. Retrieved July 16, 2007, from: http://jlarc.state.va.us/Reports/Rpt349.pdf.

[94] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[95] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[96] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[97] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[98] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

[99] Joint Legislative Audit and Review Commission. (January 2007). *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*. House Document No. 19. Retrieved July 16, 2007, from: http://jlarc.state.va.us/Reports/Rpt349.pdf.

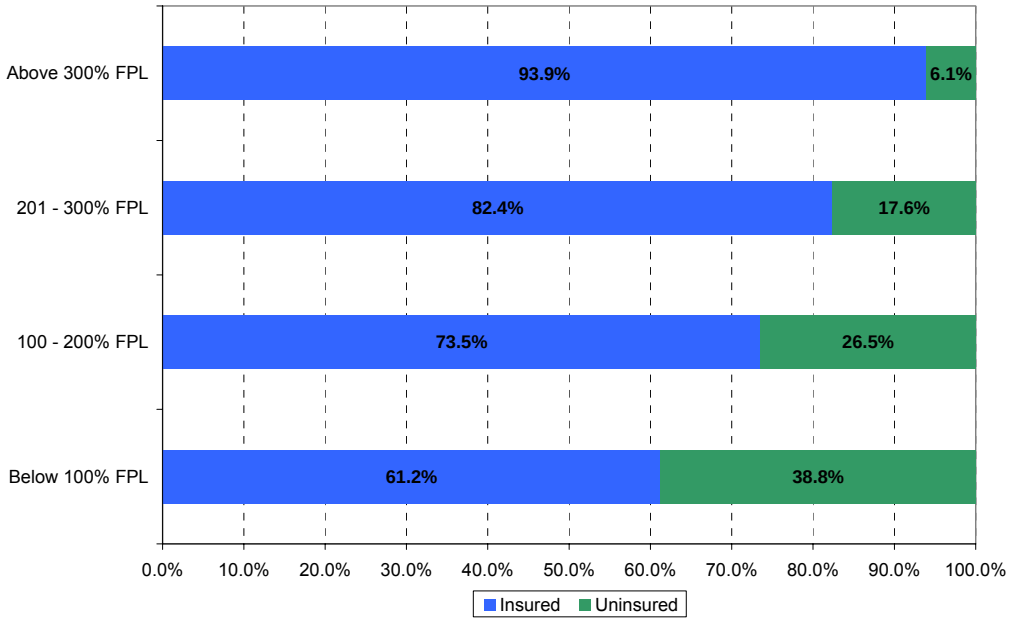
[100] The Urban Institute. (December 2006). *Profile of Virginia's Uninsured (2004-2005).* Retrieved July 17, 2007, from: http://www.hhr.virginia.gov/Initiatives/HealthReform/Workgroups/Access.cfm.

Table 1: 2007 Federal Poverty Income Levels

Family Size	100% FPL	200% FPL	300% FPL	Family Size	100% FPL	200% FPL	300% FPL
1	$10,210	$20,420	$30,630	3	$17,170	$34,340	$51,510
2	$13,690	$27,380	$41,070	4	$20,650	$41,300	$61,950

Federal Poverty Level (FPL): *Updated annually by the US Department of Health and Human Services, it is used as an indicator of annual household income.*

Figure 2: Proportion of Virginians without Health Insurance by Income Status



The Healthcare Safety Net

Currently, community-based safety net providers facilitate critical care and services to more than 400,000 Virginians each year.[101] These community-based providers consist of free clinics, health centers, local health departments, and other local or regional organizations providing care to the uninsured.

- **Free Clinics.** There are more than 52 free clinics across the Commonwealth. Free clinics provide medical, dental, mental health and pharmacy services to low-income, uninsured, and underinsured Virginians. The clinics provide healthcare services for both acute and chronic conditions as well as referrals to specialty care. Lab and diagnostic services are generally donated by local hospitals and health systems. Additional services include preventive care and patient education, including classes on managing diabetes and healthy habits. However, each free clinic is unique and different, some are open full-time and others just a few days a week depending on their resources and community needs. In addition, the scope and depth of services varies in each clinic. Free clinics are staffed predominantly by volunteers, including volunteer clinicians. Free clinics do not bill third parties for the services they provide, and many provide services free of charge. While some clinics do request a donation, no patient is turned away for their inability to pay.

- **Community Health Centers.** There are over 25 Community Health Centers (CHCs) in Virginia operating almost 80 sites. CHCs are nonprofit organizations located in medically under served areas (MUAs), providing comprehensive primary healthcare to anyone seeking care. In addition to treating individual patients, a health center emphasizes health promotion and disease prevention for entire communities. CHCs provide a wide range of services to their patients. Among the core services are: physician care, x-ray services, laboratory services, preventive services (mammography, well-child,

[101] Health Reform Commission. (February 2007). *Analysis of Survey Data from Virginia Association of Free Clinics, Virginia Department of Health, and Virginia Community Healthcare Association.*

etc.), immunizations, transportation for health services, case management, and specialty referrals. Some CHCs also offer dental care, and behavioral health services. Additionally, in order to maximize limited resources, CHCs develop linkages in the community with other private and public providers, pharmacies, nursing homes, and local business. The majority of community health centers in Virginia are Federally Qualified Health Centers (FQHCs) and many receive federal grants and funding to operate. There are also several "look-alike" health centers that meet similar operating and quality standards to FQHCs, but do not receive federal grants, only enhanced Medicare and Medicaid payments, private revenue, donations, grants, or state funds. CHCs have paid medical and other professional staff, are open full-time, and see both insured and uninsured patients.

Free clinics and CHCs excel at leveraging federal funds, grants, donations, or other reimbursements to provide care to uninsured, underinsured, and low-income people. This maximization of funds ensures that providers reach as many people in need as possible and there is a large return on investment for every dollar invested. Table 2 shows the number of patients and expenditures for these community safety-net providers.

Table 2: Safety Net Provider Patients and Expenditures

	Unduplicated Uninsured Patients	Total Expenditures for Uninsured	State General Funds Contributions	% of Total Funding
Free Clinics (CY06)[102]	51,818	$ 17,978,320	$ 1,321,400	7.3%
Community Health Centers (CY06)[103]	79,147	$ 37,361,362	$ 791,871	2.1%

While free clinics and CHCs achieve a significant return on investment, surveys of these organizations indicate there are still many unmet community needs and many people with no regular source of healthcare. Many of these providers report waiting lists and it can take up to 6 weeks to get an appointment for a primary care physician visit. The 130,965 uninsured people served by these two types of organization in 2006 are only 22 percent of uninsured low-income Virginians.[104]

Local health departments (LHDs) also serve as community safety-net providers. They are operated and administered by the Virginia Department of Health (VDH).[105] LHDs provide clinical preventive services that vary based on community need and resources, but typically include women's health services, child health services, immunizations, infectious disease prevention, screening, and control, nursing home pre-admission screening, limited pharmacy and laboratory services, dental, and Women, Infant, and Children (WIC) nutritional services. LHDs may also offer case management, health education, personal care services, and school health in their communities to the extent funding is available.

In many areas of the state, LHDs work closely with the free clinics, CHCs, and other safety net providers in their area to bolster the community's safety net for the uninsured. Funding for LHDs includes state general funds, local matching funds, reimbursement from Medicaid, Medicare, commercial insurers, patient payments, private donations, federal grants, and other grants. IN 2006, LHDs provided health care, dental, and WIC services to 637,791 patients.[106] As government entities, LHDs received over $46 million in state general funds in SFY2006 to provide these services.

[102] Virginia Health Care Foundation (September 2007). This does not include community safety net providers that are not members of VAFC.

[103] Virginia Health Care Foundation (September 2007). This does not include community safety net providers that are not members of the VACHA.

[104] Health Reform Commission staff calculation based on number of uninsured Virginians below 200% FPL. Urban Institute data indicates there are 600,000 uninsured Virginians with incomes below 200% FPL.

[105] Except Arlington and Fairfax Counties, which are administered by their respective local governments.

[106] Virginia Department of Health (September 2007).

Virginia's Medicaid and FAMIS Programs

Authorized under Title XIX of the Social Security Act, Medicaid is a healthcare program financed jointly by Virginia and the federal government. Medicaid provides health insurance coverage to low income children, pregnant women, the elderly, persons with disabilities, and parents of children enrolled in Medicaid. Table 3 shows eligibility levels for the Medicaid and FAMIS programs (FAMIS is described below).

Table 3: Virginia's Medicaid and FAMIS Eligibility Levels[107]

	% Federal Poverty Level		
Coverage Group	**Federal Minimum Eligibility**	**Medicaid**	**FAMIS**
Pregnant Women	133%	133%	185%
Infants (0-1 years)	133%	133%	200%
Children (1-5 years)	133%	133%	200%
Children (6-18 years)	100%	133%[108]	200%
Parents	N/A	24%	N/A
Aged, Blind, and Disabled	N/A	80%	N/A

Medicaid is administered by the Virginia Department of Medical Assistance Services (DMAS). The federal government provides 50 percent federal financial participation or "match" for every dollar spent by the Commonwealth for Medicaid. For example, if a physician's visit cost $100, the state would pay $50 for the visit and the federal financial participation would be $50. In FY 2006, Virginia Medicaid program expenditures were $4.86 billion, approximately 50 percent are state expenditures.[109] The Virginia Medicaid population served 490,629 children, 121,628 parents or caretakers of children, 86,540 elderly persons, and 170,956 adults who are blind or who have disabilities during that time period.[110]

Virginia's Medicaid program covers a broad range of services with some nominal cost sharing for enrollees. Services include inpatient and outpatient hospital care, physician, nurse midwife, and pediatric and family nurse practitioner services, federally qualified health center and rural health clinic services, laboratory and x-ray services, prenatal care, family planning services, transportation services, routine dental care for people under age 21, prescription drugs, rehabilitation services such as occupational, physical, and speech therapy. It also pays for skilled nursing facility care and home healthcare services for persons over age 21 who meet certain qualifications, intermediate care facilities for persons with mental retardation and developmental disabilities (MR/DD), and mental health services.[111]

Virginia's Family Access to Medical Insurance Security program (FAMIS) is the Commonwealth's state children's health insurance program. FAMIS is jointly funded by the state and federal government and administered by DMAS. Children and pregnant women receive services through the program up to 200 percent of the Federal Poverty Line (FPL) and 185 percent FPL, respectively (Table 2).

Virginia receives 65 percent federal financial participation for FAMIS expenditures; for every $100 for a physician visit, the federal government pays $65 dollars. FAMIS provides health insurance to cover doctor visits, well-baby checkups, hospital visits, vaccinations, prescriptions, lab tests and x-rays, dental care,

[107] Kaiser Family Foundation. (July 2007). *State Health Facts.* Retrieved July 27, 2007, from: www.statehealthfacts.org.

[108] Medicaid (Title XIX) provides the funding source up to 100% FPL. FAMIS (Title XXI) provides funding from 100-133% FPL as an Medicaid expansion program.

[109] Department of Medical Assistance Services. (August 2007). Total unduplicated enrollees.

[110] Department of Medical Assistance Services. (August 2007). Total unduplicated enrollees.

[111] Department of Medical Assistance Services. (2006). *The Statistical Record of the Virginia Medicaid Program, FY2006 Edition.* Retrieved August 3, 2007, from: http://www.dmas.virginia.gov/ab-2005_stats.htm.

emergency care, vision care, and mental healthcare.[112] In FY2006, Virginia's FAMIS program enrolled an average of 75,632 individuals each month[113] and had total expenditures of $140.7 million.[114]

Table 4 shows Virginia's national eligibility rank compared to other states for these programs.[115]

Table 4: Virginia's National Eligibility Rank

	Virginia Medicaid	Virginia FAMIS	National Rank (1 = highest eligibility level)
Pregnant Women	133%	185%	18th (tie with 20 other states)
Infants (0 – 1 years)	133%	200%	20th (tie with 20 other states)
Children (1 – 5 years)	133%	200%	20th (tie with 20 other states)
Children (6 – 18 years)	133%	200%	20th (tie with 20 other states)
Working Parents	31%	N/A	46th
Non-Working Parents	24%	N/A	42nd

The Private Health Insurance Market

Approximately eighty percent of non-elderly insured Virginians receive healthcare coverage through their employer.[116] Employer sponsored insurance is offered in large and small group markets in Virginia. Data indicates 30 percent of employers in Virginia are large group employers and 98 percent offer health insurance to their employees through fully insured or self insured group plans.[117] In the small group market fewer employers offer health insurance because of premium costs.[118]

All of Virginia's health insurance markets are experience-rated, allowing insurers to underwrite policies for individuals or groups. This gives insurers the flexibility to increase or decrease monthly premiums based on the risks within large and small groups purchasing insurance as well as for individuals purchasing policies. However, the Commonwealth has created the Standard and Essential health plans for small groups who have members with high-cost medical conditions. These plans must be offered by insurers in the small group market and cap monthly premiums at 120 percent of the average small group price. In addition, open enrollment or guaranteed issue is required in the individual market, protecting individuals from completely losing access to coverage if they have a high cost medical condition, although there may be a waiting period for individuals with pre-existing conditions.[119]

The major insurer in Virginia is Anthem Blue Cross Blue Shield. There are several other health plans who also offer insurance including United Healthcare, Aetna, CIGNA, Coventry, Care First, and Kaiser Permanente. The regulatory environment in Virginia has allowed insurers to develop a diverse array of

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[112] Family Access to Medical Insurance Security. Retrieved August 3, 2007, from: http://www.famis.org/geninfo.cfm?lang=English.

[113] Department of Medical Assitance Services. (July 2007). Medicaid expansion (100-133% FPL) and FAMIS individuals.

[114] Department of Medical Assistance Services. (July 2007).). Medicaid expansion (100-133% FPL) and FAMIS individuals.

[115] Kaiser Family Foundation. (July 2007). *State Health Facts.* Retrieved July 27, 2007, from: www.statehealthfacts.org.

[116] Joint Legislative Audit and Review Commission. (January 2007). *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*. House Document No. 19. Retrieved July 16, 2007, from: http://jlarc.state.va.us/Reports/Rpt349.pdf.

Non-elderly Virginians are residents less than 65 years of age. All US citizens receive Medicare at age 65. Five percent of non-elderly insured Virginians purchase health insurance through the individual insurance market and 15 percent from public programs such as Medicaid or FAMIS.

[117] Joint Legislative Audit and Review Commission. (January 2007). *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*. House Document No. 19. Retrieved July 16, 2007, from: http://jlarc.state.va.us/Reports/Rpt349.pdf.

[118] Stanton, M. (September 2004). *Employer Sponsored Insurance, Trends in Cost and Access.* Retrieved August 3, 2007, from: http://www.ahrq.gov/research/empspria/empspria.htm#Factors.

[119] Bureau of Insurance. *Virginia Health Insurance Guide.* Retrieved August 3, 2007, from: http://www.scc.virginia.gov/division/boi/webpages/inspagedocs/healthinsguide.pdf.

products in the large group and small group markets. As a result, Virginia's employer-sponsored insurance rate, while declining, is significantly higher than the national average.[120] However, for individuals with high-cost or high-risk medical conditions, Virginia's experience-rated market can be barrier to coverage in the individual marketplace. While health insurers must issue policies to these high-risk individuals, the policy premiums may be unaffordable. In addition, small-groups might be priced out of the market because of the high medical costs of just a few employees.

WHY PURSUE POLICY CHANGE?

The significant number of uninsured Virginians indicates an ongoing challenge for the Commonwealth. While safety net providers and the Medicaid and FAMIS programs are providing valuable services to low-income and/or uninsured Virginians, rising demand for these programs may soon outpace resources. The number of low-income working uninsured residents, young adults without health insurance, and the number of businesses that are not offering coverage to their employees indicates that the current network of safety net care, Medicaid, FAMIS, and private health insurance are not meeting the needs for a substantial group of Virginia's residents. New options and vehicles need to be developed to make health insurance and healthcare services accessible and affordable for all residents. Increased access to the most basic primary healthcare for Virginia's one million uninsured residents can improve worker productivity, reduce chronic illness, and improve overall population health outcomes in the Commonwealth.

RECOMMENDATIONS

The Access to Care Workgroup sought to identify options that will provide access to care or health insurance for the greatest number of people and will provide the greatest return on investment. In other words, those models that reach the most people and delivered care the most effectively and efficiently while maximizing state, federal, and private funds.

More Frequent Study of Virginia's Uninsured and Medicaid Provider Access

A. In 2004, the VDH conducted the Virginia Healthcare Insurance and Access Survey to determine how many Virginians were uninsured, measure the demographics of this population, and examine how these residents accessed healthcare services. In 2006, the Virginia Healthcare Foundation, in partnership with JLARC, retained the Urban Institute to study Virginia's uninsured using data from the Virginia Department of Health's survey and US Census Current Population Survey. These two studies yielded un-insurance rates of 8.9 percent (632,138 residents) and 15.5 percent (1 million residents), respectively.[121] This variability points to the need to develop a consistent, annual, or biennial survey of Virginia's uninsured.

   An annual or biennial survey of Virginia's uninsured would permit the Governor and General Assembly to benchmark and monitor the success of initiatives to cover Virginia's uninsured. It would create a systematic understanding of the challenges of this population and allow policymakers to target population groups or geographic areas to increase the number of insured residents.

   Any study would use a consistent methodology year-over-year and be a collaboration between the VDH's Office of Minority Health and Public Health Policy and the Virginia Healthcare Foundation. These entities seek to understand and monitor Virginia's uninsured populations as

[120] Kaiser Family Foundation. (October 2006). *Changes in Employees' Health Insurance Coverage 2001-2005.* Retrieved August 3, 2007, from: http://www.kff.org/uninsured/7570.cfm.

In 2004, 61% of people received healthcare coverage through their employer or their spouse's employer.

[121] Joint Legislative Audit and Review Commission. (January 2007). *Options to Extend Health Insurance Coverage to Virginia's Uninsured Population*. House Document No. 19. Retrieved July 16, 2007, from: http://jlarc.state.va.us/Reports/Rpt349.pdf.

part of their organizational missions and have worked collaboratively on many initiatives over the last 15 years.

- *The Secretary of Health and Human Resources should request the Virginia Department of Health to work collaboratively with the Virginia Healthcare Foundation to conduct an annual or biennial survey of Virginia's uninsured.*

B. There is concern that inadequate Medicaid provider payments may limit the availability of Medicaid providers. Yet, there is no system wide data indicating where there may be inadequate payment in either the Medicaid managed care or fee-for-service sectors. In September 2006, the federal Medicaid Commission heard testimony indicating that the Virginia Medicaid fee-for-service program had an 8.3 percent cumulative increase in fees from 1998-2003, while on average all other states experienced a 27.4 percent cumulative increase.[122] Adequate Medicaid reimbursement rates are essential and fundamental for Medicaid enrollees to access healthcare. Access to Care Workgroup members support adequate Medicaid reimbursement rates to improve access to care as a first step more data should be collected.

- *The Governor, through the Secretary of Health and Human Resources, should require the Department of Medical Assistance Services to periodically assess enrollee access to Medicaid fee-for-service and managed care providers.*

Strengthen Community-Based Safety Net Providers

Free clinics and health centers are an essential provider of care and further investment by Virginia will improve access to care for many uninsured residents. The Workgroup believes additional state General Funds should be allocated for free clinics and health centers to:

- Support safety-net provider operating costs. Currently, free clinics and health centers must rely on private donations or grants to support ongoing operations. State funding for a portion of these costs would allow free clinics and health centers to maximize private resources, federal matching funds, and grant funds. This would allow sites to stabilize operations, retain needed staff, and implement systematic building blocks for future expansion.

- Expand access to healthcare services. State funding to expand access to care would allow free clinics and health centers to maximize existing funds steams to enhance the scope of services offered to the uninsured and build capacity at their sites. New funding would also include designated funding specifically for the expansion of dental services to the uninsured.[123]

- Promote local and regional collaboration. Many organizations that provide services to the uninsured are coming together in communities and regions to coordinate care, reduce duplication of services, and to establish care networks. These community organizations need resources and flexibility to provide services and reach out to the uninsured in their community in effective ways. In addition, grassroots organizations that serve the uninsured, but are not part of the free clinic or health center associations need expertise and support to reach more citizens and professionalize their organizations.

- Establish data-driven planning. Currently, there is no statewide comprehensive information about medically underserved areas and where the uninsured and/or insured have inadequate access to healthcare services. The Workgroup envisions development of a statewide plan, supported through careful data analysis, by the VDH. The statewide plan would allow the state

[122] Milligan, C. Center for Health Program Development and Management, UMBC. *Medicaid Reimbursement Policy.* Presented to Medicaid Commission Meeting, September 2006.

[123] Access to dental care was noted as a significant need for low-income adults in Virginia. See recommendation 4B for more information.

to consistently document trends to support obtaining federal medically underserved designations and identify areas in need of additional safety net services. It would also provide a mechanism to steer future state funding for the safety net and develop new programs such as state "look-alike" health centers.

There are several existing state-affiliated vehicles in the Commonwealth that distribute funding to community-based safety net providers, the Virginia Association of Free Clinics the Virginia Community Health Care Association, the Virginia Department of Health and the Virginia Healthcare Foundation. They are important partners in the distribution of funding, provision of technical assistance, regional collaboration, and identifying safety net needs. This recommendation envisions that these activities would continue to be funded through a combination of funding directly to these entities to distribute to their constituencies.

The Access to Care Workgroup believes that this infusion of funding should be distributed with the aim of sustainability. The principle of sustainability will require all entities to leverage the Commonwealth's investment. This will include reaching new populations if the Medicaid program changes, securing new funding options, and identifying ways to operate their organization through careful planning, fundraising, building community relationships, and service line development. As part of this sustainability effort, the Workgroup envisions that safety net providers will maintain or increase current levels of funding to ultimately expand capacity of programs.

- *The Commonwealth should commit additional new funding for community-based safety net providers to stabilize their operations, expand access to healthcare services, and coordinate services across communities for Virginia's uninsured.*

Table 5 outlines the recommended distribution of additional new funds based on operating costs and service capacity of safety net providers.

Table 5: Recommended Distribution of $10 Million Additional Safety Net Funds

Organization	Additional State General Funds	Explanation
VACHA	$3.7 million	This sum is approximately 10% of total community health center operating costs for uninsured patients.
VAFC	$3.6 million	This sum is approximately 20% of total free clinic operating costs. Free clinics do not serve Medicaid or other insured clients.
VHCF	$2.0 million	Intended for expanding access to care through free clinics, health centers, and other organizations dedicated to providing healthcare to low-income and uninsured Virginians.
VHCF	$700,000	Intended for increasing capacity for dental services for uninsured adults (see recommendation 3B).
Total	$10 million	

Insure More Low-Income Virginians through the Medicaid and FAMIS Programs

A. Virginia's Medicaid eligibility levels for children, pregnant women, seniors, and people with disabilities are significantly higher than eligibility levels for low-income adults. Currently, caretaker adults or parents are only eligible for Medicaid if they earn less than 24 percent FPL or less than $5,000 per year for a family of four (Table 3). The national average for working parents or caretaker adults is 65 percent FPL and 42 percent FPL for non-working parents or caretaker adults.[124]

[124] Kaiser Family Foundation. (July 2007). *State Health Facts.* Retrieved July 27, 2007 from: www.statehealthfacts.org.

Uninsured low-income parents are less likely to have a medical home or receive recommended preventive care and screenings. They are also more likely to miss work due to illness.[125] In addition to their own difficulties finding and receiving healthcare, a recent study from The Kaiser Commission on Medicaid and the Uninsured shows that uninsured parents are three times more likely than parents with private health insurance or Medicaid to have uninsured children.[126] This study complements earlier research indicating a link between parental health insurance coverage and better prevention and wellness care for children.[127]

Ensuring low-income parents and caretaker adults have access to appropriate and affordable healthcare should be a major priority for the Commonwealth. Providing Medicaid to this targeted group will prevent long-term illness and disability and may increase low-income children's access to medical services. The Medicaid program is an effective vehicle to reach low-income uninsured Virginians because of the program's federal financial participation; the state will receive significant additional dollars for state General Funds it invests in healthcare for this population.

Table 6: Estimated Increase in Parent Enrollees

Current Parents Covered (Avg. Eligibility 24% FPL)	Additional Parents Covered	
	Expansion from 24% to 65% FPL	Expansion from 24% to 100% FPL
88,688	19,183 - 37,127	42,482 - 65,338

DMAS estimates that between 19,183 and 37,127 additional parents could have health insurance if Medicaid eligibility was expanded to the national average for working parents of 65 percent FPL. If eligibility was increased to 100 percent FPL to align it with Virginia's other eligibility groups, between 42,482 and 65,338 additional low-income parents or caretaker adults could receive healthcare coverage (Table 6).

- *The Governor should recommend expanding Medicaid eligibility to 100 percent FPL for parents and caretaker adults ages 19-64.*

B. Many low income adults suffer from numerous dental problems that are directly related to their overall health. Poor oral health has been linked by research to a multitude of health problems such as diabetes, heart disease, and adverse pregnancy outcomes. People with periodontal disease are one-and-a-half to two times as likely to suffer a fatal heart attack and nearly three times more likely to suffer a stroke than those with strong oral hygiene.[128] Additionally, studies have indicated that chronic oral infections can foster the development of clogged arteries and blood clots, and periodontitis can make diabetes worse as diabetic patients with severe periodontitis have greater difficulty maintaining normal blood sugar levels.[129]

With the proven correlation between oral health and total health, preventive dental care has become essential. Unfortunately, many low income families do not have access to quality dental care in Virginia. Free clinics have seen over a 100 percent increase in dental visits in the last five years and community health centers have provided over 42,000 dental visits last year.[130,131]

[125] Kaiser Commission on Medicaid and the Uninsured. (June 2007). *Spotlight on Uninsured Parents: How a Lack of Coverage Affects Parents and Their Families.*

[126] Kaiser Commission on Medicaid and the Uninsured. (June 2007). *Spotlight on Uninsured Parents: How a Lack of Coverage Affects Parents and Their Families.*

[127] Ku, L. and Broaddus, M. Center on Budget and Policy Priorities (October 2006). *Coverage of Parents Helps Children, Too.*

[128] Gilbert, S. New York Times. (August 5, 2003). *Oral Hygiene May Help More Than Teeth and Gums.*

[129] American Diabetes Association. *Oral Health & Oral Hygiene.* Retrieved August 3, 2007, from: www.diabetes.org.

[130] Virginia Association of Free Clinics Survey. (February 2007).

While the number of adults who have visited a dentist in the last year in Virginia is above the national average according the 2004 Behavioral Risk Factor Surveillance Survey, Virginians with incomes less than $25,000 are far less likely to have had a dental visit.[132]

Currently, Virginia only provides emergency dental service to adults enrolled in Medicaid.[133] If dental services were added as a Medicaid service for currently enrolled Medicaid adults, over 88,000 individuals could access dental services. Table 5 shows how many more adults would have access to dental care if Medicaid eligibility was raised for low-income parents and caretaker adults.

- *The Governor, through the Secretary of Health and Human Resources, should require the DMAS to obtain federal approval to provide routine dental services as part of any Medicaid eligibility expansion to parents, or*

- *The Governor, through the Secretary of Health and Human Resources, should require the DMAS to obtain federal approval to provide routine dental services for parents currently enrolled in Medicaid.*

C. The federal Congress is currently debating the reauthorization of the State Children's Health Insurance Program (SCHIP). FAMIS, Virginia's version of the program, currently covers children up to 200 percent FPL (Table 2). The reauthorization debate in both the House and Senate allots significant amounts of money to states to expand their SCHIP programs and/or reach out to children who are eligible for their existing programs, but not enrolled. In these proposed bills, states may be allotted funds based on their previous or current SCHIP spending. Consequently, states with eligibility levels higher than 200 percent FPL would receive more federal dollars in the future to operate their SCHIP programs. However, if Virginia elects to expand eligibility this year, the Commonwealth may receive larger future allotments of funds for the FAMIS program. This would ensure Virginia would be able to reach as many low-income children as possible this year and until the next SCHIP reauthorization (likely in FFY2012).

   DMAS estimates that an expansion of FAMIS eligibility for children from 200 percent FPL to 300 percent FPL could allow an additional 21,200 children to enroll in the FAMIS program. As part of this expansion, DMAS would enhance its efforts to reach children who are currently eligible for Medicaid and FAMIS, but not enrolled in these programs. This would further increase child enrollment in Medicaid and FAMIS.

   - *The Governor should recommend an expansion of FAMIS eligibility from 200 percent FPL to 300 percent FPL for children up to age 18 and allocate funds to DMAS to aggressively pursue children who are eligible, but not enrolled in the current FAMIS and Medicaid programs.*

D. Virginia must continue to reduce premature births and infant deaths (see the Prevention Chapter for more information). An essential component of reducing infant mortality and adverse birth outcomes is access to early and affordable prenatal care. The Medicaid and FAMIS programs provide health insurance to pregnant women up to 185 percent FPL. Expanding eligibility from 185 percent FPL to 200 percent FPL for pregnant women will provide coverage to nearly 500 additional low-income women.

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[131] Virginia Community Healthcare Association Survey. (February 2007).

[132] Centers for Disease Control and Prevention. *National Oral Health Surveillance System: 2004 Behavioral Risk Factor Surveillance System.* Retrieved August 1, 2007, from: http://www.cdc.gov/nohss/.

[133] Kaiser Family Foundation. *Medicaid Benefits: Online Database.* Retrieved August 3, 2007, from: www.kff.org.

- *The Governor should propose an increase in FAMIS eligibility for pregnant women from 185 percent FPL to 200 percent FPL*

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Virginia's Working Uninsured through Private Health Insurance Programs

Virginia has a large group of residents who are uninsured low-income workers. There are few public or private health insurance options for this population. For those outside of the Medicaid eligibility criteria, private insurance is either not offered by employers or it is unaffordable. Insurance take-up is largely dependent upon premium costs as a percent of household income. As premiums increase, uninsured people are less likely to purchase a health insurance product. Research suggests no premiums should cost more than 5 percent of annual household income to ensure affordability and take-up in the uninsured population.

Evidence from other states suggests innovative private insurance products with affordable monthly premiums can be appealing to low-income working uninsured residents and spur small employers to offer coverage. Tennessee recently introduced Cover TN which provides affordable health insurance to small businesses. There is a partnership with the state, small employers, and employees to finance the product. Since its inception in March 2007, over 5,000 people have enrolled in the program.[134] New York State has also offered an innovative program called Healthy NY for small businesses and their employees; it has enrolled over 100,000 residents.[135]

The Virginia Department of Health Office of Minority Health and Public Health Policy has been awarded State Planning Grant funds by the US Health Resources and Services Administration to examine the problem of the uninsured in Virginia and explore alternatives fro expanding health insurance coverage since 2003.[136] In 2006, the Virginia State Planning Grant program recommended a program where eligible individuals would receive health insurance coverage through private insurers for up to a $50,000 in claims each policy year (called a Capped Product). The State Planning Grant Program estimated a Capped Product would have a total monthly premium of $135 for an individual.

The Capped Product would be available to working individuals who work for small employers (less than 50 employees) in Virginia and who have been either uninsured or whose employer did not offer health insurance for at least the last 6 months. Small employers could offer the product if they have not offered health insurance to their employees for at least the last 6 months. Individuals could also purchase the product on their own.

To address affordability of monthly premiums, working uninsured individuals earning less than 200 percent FPL would be eligible for the Three-Sharing Financing Model. The model requires employers to contribute a third, the Commonwealth to contribute a third, and employees to contribute a third toward monthly health insurance premiums. For example, a $135 monthly premium, a person would pay $45 a month, an employer $45, and the Commonwealth $45. This model, in many cases, would make employees' monthly premium payments less than 5 percent of their annual, gross household income. Individuals with incomes above 200 percent FPL could purchase the Capped Product, but would not qualify for the Commonwealth one-third contribution.

The Commonwealth could partner with private health insurers to offer the Capped Product and Three-Share Financing Model, allowing some variation and flexibility in the program for private

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[135] EP&P Consulting. (January 2007). *Report on the Healthy NY Program 2006.*

[136] The Virginia State Planning Grant Program began in 2003 and required Virginia participants to develop methods to expand health insurance coverage to working uninsured citizens who are employed in small businesses and households with incomes between 100% to 300% FPL. Virginia Department of Health was the administrator of the Grant Program. More information is available at www.insuremorevirginians.org.

insurers. Virginia would also take an active role in designing a proactive, comprehensive, social marketing strategy aimed at elevating demand for health insurance coverage through a designated entity or organization. This designated entity would also be accountable for working with private insurers, employers, insurance agents, and others as well as accountable for meeting specific enrollment targets.

The Access to Care Workgroup believes a private health insurance model featuring a Capped Product and Three-Share Financing could provide significant first dollar coverage to working uninsured citizens who have few other health insurance options.

- *The Governor, through the Secretary of Health and Human Resources, should introduce legislation and a budget amendment to create a private health insurance product for working uninsured Virginians and small businesses who have limited access to other health insurance options.*

ESTIMATED COSTS

Table 7: Pricing of Access to Care Workgroup Recommendations (Annual Estimated Costs)

1A. Annually or biennially study Virginia's uninsured population	$ 0
1B. Evaluate Medicaid provider access biennially	$ 0
2A. Provide $10 million in state General Funds to the community-based healthcare safety net annually	$ 10,000,000
3A. Expand Medicaid eligibility to 100% FPL for parents and caretaker adults ages 19-64 (includes 3B)[137]	$ 84,000,000 to $ 127,500,000
3B. Include routine dental services as part of any Medicaid eligibility expansion for parents, or include routine dental services for existing parents enrolled in the Medicaid program	See 3A
3C. Expand FAMIS eligibility from 200% FPL to 300% FPL for children[138]	$ 2,000,000
3D. Increase FAMIS eligibility for pregnant women from 185% FPL to 200% FPL	$ 1,600,000
4A. Create a private health insurance product for uninsured Virginians with incomes less than 200% of FPL who no other access to public or private health insurance	$ 20,000,000
Total	**$ 117,600,000-$ 161,100,000**

[137] Joint Legislative Research and Audit Commission. (January 2007). *Range Reflects Preliminary DMAS Estimates Based on CPS Data.* House Document No. 19.

[138] Preliminary DMAS estimate. Does not include additional Medicaid and FAMIS costs associated with reaching currently eligible, but not enrolled children.

IMPROVING QUALITY, INCREASING TRANSPARENCY, AND PROMOTING PREVENTION

The Quality, Transparency, and Prevention (QTP) Workgroup was tasked with developing a road map to promote quality in healthcare, increase pricing and quality transparency between consumers and healthcare providers, and advance prevention efforts to improve health outcomes. The Workgroup focused on three specific proposals: (1) Quality -- a Medicaid nursing home quality incentive program, (2) Transparency -- a website portal enabling consumers to access pricing and quality information, and (3) Prevention -- a proposal plan to reduce infant mortality, prevalence of obesity, and tobacco use. The QTP Workgroup held six sessions over six months to develop recommendations for consideration by the Health Reform Commission.

The following section of the report summarizes the QTP Workgroup's recommendations for development of a Medicaid nursing home pay-for-performance (P4P) program. During the 2006-2007 legislative session, the Department of Medicaid Assistance Services (DMAS) was directed by the Virginia General Assembly (via HB 2290) to develop a Nursing Facility Quality Improvement Program. Similarly, Virginia's 2007 Budget further directed DMAS to develop a P4P proposal for Medicaid nursing homes. In light of these legislative actions, the QTP Workgroup focused their discussion on ways it could provide input to help shape this quality improvement effort; the Workgroup did not evaluate the merits of P4P methods in promoting quality in public sector care.

BACKGROUND – QUALITY

Interest among State policymakers for quality-based purchasing initiatives, namely "pay-for-performance" (P4P), and similar incentive-oriented programs have grown over the past decade. The use of P4P incentives is based on the premise that current payment systems do not promote quality and may at times reward poor performance and poor practices. Aligning payment incentives with desired outcomes creates opportunities to use financial rewards to encourage the use and adoption of evidence-based care processes and best practices. Virginia must accelerate its quality initiatives in order to significantly improve its healthcare system.

The concept of aligning payment policies with quality improvement is supported by a number of entities, including the Institutes of Medicine (IOM), the American Association of Homes and Services for the Aging (AAHSA), and the Alliance for Health Reform. The IOM *Crossing the Quality Chasm* 2001 report called for public and private purchasers to reexamine payment policies and build stronger incentives to promote quality enhancement. The report encouraged the development of programs to "identify, pilot test, and evaluate various options for better aligning payment methods with quality improvement goals". The AAHSA called for demonstrations to develop and test methods of paying bonuses to high performing facilities; and the Alliance for Health Reform supports the use of payment incentives for facilities with better performance scores. Although the practice of aligning incentives with quality outcomes is promising, further research is needed to uncover the appropriate measures and structural program elements needed in order to ensure such programs achieve the desired results cost-effectively.[139]

The success of a P4P program will be determinant upon its design, implementation, evaluation, and continued refinement. Key to each stage will be to ensure "buy-in" from participants, the use of meaningful metrics, and the provision of appropriate rewards linked to quality outcomes. The commitment level of participants to improve quality will also be dependent on the culture of their work environment or organization. A sustainable P4P system can be one tool used to steer individuals and entities towards valuing a culture dedicated to high performance, safety, and quality.[140]

Nursing Home P4P Programs

Although the use of P4P practices in healthcare has primarily been implemented in private-sector programs designed to reward hospitals and physicians for achieving quality targets. P4P initiatives are increasingly emerging in public-sector arenas, such as federal Medicare and state Medicaid programs. The implementation of P4P programs designed for nursing facilities has been pursued by at least eleven states, although not all remain active. The Centers for Medicare and Medicaid Services (CMS) are also developing a national nursing home P4P project, known as the Nursing Home Quality-Based Purchasing (NHQBP) demonstration. The demonstration will be a three-year project to improve the quality of care furnished to Medicare recipients in nursing facilities and will test the value of using incentive programs to improve the quality of nursing home care. The demonstration is projected to move forward after 2008.[141]

States that have implemented quality reimbursement programs for nursing facilities have used a variety of measures to assess quality and reward high performance. The mix of measures typically used includes minimum data set (MDS) measures on resident outcomes, staffing measures, certification survey deficiencies, and resident and family quality of life or satisfaction scores. The reward structures from each state program also vary and include both non-financial and financial incentives. A brief description of select state nursing home P4P systems is provided in Appendix H, the relative mix of outcome

[139] Institute of Medicine. (2001). *Crossing the Quality Chasm: A New Health System for the 21st Century*. Washington, DC: National Academy Press.

[140] Dow, A. (2004). "Issues to Consider in Implementing a Pay-For-Performance Program." *Office of the Auditor for the Metro Council*. Portland, OR.

[141] Abt Associates. (June 2006). "Quality Monitoring for Medicare Global Payment Demonstrations: Nursing home Quality Based Purchasing Demonstration."

measure types used for select programs is provided in Appendix I, and the types of measures used in Nursing Home P4P payment systems are provided in Appendix J.

RECOMMENDATIONS

The following recommendations, developed by the Quality, Transparency, and Prevention (QTP) Workgroup, should serve as a framework for the development of DMAS's Nursing Home P4P program. The recommendations encompass five areas: structural components, measurement components, incentive structure, program evaluation, and public reporting. Based on the research and presentations from the Workgroup meetings, the Workgroup believes that for a Nursing Home P4P program to be successful several key design elements, as follows, must be considered in order to promote good performance.

Structural Components

Measurement Structure

Selected performance measures need to be meaningful for facilities and linked to quality improvement for residents. Structural measures (i.e., the organizational capacity to provide quality care), process measures (i.e., performance to achieve quality care), and outcome measures (i.e., the result of quality care) should all play some part in the overall measurement scheme developed. The QTP Workgroup recommends selecting metrics that: (1) facilities can control, (2) are scientifically valid and reliable, and (3) are linked to quality outcomes. Rotating measures and focusing measures on areas of concern should be considered. For example, measures aimed to reduce the occurrence of pressure ulcers among nursing home residents would help target one area in need of improvement within the Commonwealth. Other health areas of concern for residents should be identified and prioritized, especially those areas where the Commonwealth may lag behind other states.

Scoring System

Examples from other state programs and the proposed CMS demonstration should serve as helpful resources in the development of a scoring system. Some state programs (Iowa and Kansas, for example) have implemented simple scoring systems that reward a small number of points for select criteria. In contrast, recommendations from Abt Associates for the CMS nursing home P4P demonstration include developing a scoring system based from a large range of values or domains to emphasize an "overall" performance score rather than emphasize performance for an individual measure or set of measures in a particular category. Although it is recommended, utilizing a large range scale may be more burdensome for data collection, and more complicated for facilities to determine what level of performance will earn them a performance bonus in advance. The difficulties encountered from using a more complicated scale could result in a less transparent scoring system for both providers and consumers. An appropriate scoring system used to rank nursing facilities and give bonuses to top performers will need to be further evaluated by DMAS and its stakeholder workgroup.[142]

Measurement Scale

The use of a relative versus an absolute scale for selected measures will need to be determined. A relative scale would award providers for improving a certain percentage without their being a minimum threshold value to attain, while an absolute scale would reward providers only if they reach a minimum threshold value. Rewarding on a relative scale may incentivize those with low baselines to achieve incremental improvement. Alternatively, rewarding on an absolute scale may motivate all participants to attain or surpass a pre-defined minimum level of quality care; or

[142] Abt Associates. (June 2006). "Quality Monitoring for Medicare Global Payment Demonstrations: Nursing home Quality Based Purchasing Demonstration."

potentially, the absolute scale may just reward those who are already achieving the level of results desired.

If the Commonwealth were only to use an absolute scale for all measures, there would be no incentive for "lower performers" to try to improve because the benefit gained from improvement would be significantly outweighed by the hurdle to reach a minimum threshold. However, having a P4P program based only on a relative scale could result in decreasing the overall performance level of all providers in the Commonwealth if minimum standards are not maintained. Therefore, there should be incentives for both the overall relative improvement (such as X percent improvement from baseline) and achievement of an absolute threshold (such as Y level of nursing staff care). The balance between the uses of the two scale types for the various measures selected will be determinate upon desired goals for each measure selected (i.e., improving low performers vs. maintaining a certain level of performance vs. both).

Program Initiation: Voluntary program and pilot test

The program should initiate as a voluntary program designed to encourage facility involvement by providing strong financial incentives to drive participation. Rewarding facilities a minimal financial amount for participation in the program, regardless of performance, is a method used by some state P4P programs to encourage enrollment and help provide a funding resource for facilities to report measures. Creating methods to draw participation by facilities should be considered in the development of the P4P program.

The proposed measures for the P4P program should be pilot tested using non-financial incentives. Non-financial incentives could include special recognition for achieving targets, differential intensity of oversight, or reductions in administrative burdens. Additional recognition could also be provided to facilities that participate as a "ground-breaker" participant to test the development, implementation and refinement of the program structure. Measures and program elements determined to be effective and useful during the pilot test should then be transitioned to a financial reward system.

- *The Governor should require the Nursing Home P4P program include the use of meaningful metrics linked to quality improvements that balance both absolute and relative scales, as appropriate. The program should begin as a voluntary program and the proposed measurement system should be pilot tested. Non-financial incentives should be used during the pilot-test before transitioning effective program components to a financial reward system.*

Measurement Components

State Medicaid Nursing Home P4P programs that currently operate primarily use measures derived from four areas: MDS Quality Measures, Nursing Home Staffing Measures, Quality of Life or Satisfaction Measures, and State Survey Inspections. A description of each category of measures is provided below.

- MDS Quality Measures on Resident Outcomes

  These nursing home quality measures come from resident assessment data that nursing homes routinely collect at specified intervals during their stay. The measures assess the resident's physical and clinical conditions and abilities. CMS uses a host of nursing home quality measures; it would be useful to focus on a workable subset of these measures, rotate the measures, and/or target specific areas in need of improvement. Efforts should be made to identify areas of concern within Virginia where improvement is needed and the use of incentives could spur higher quality outcomes. For example, concerns over pressure ulcers, fall injuries, anti-psychotic medication use, and physical restraints could be potential areas to target quality improvement efforts.

- Nursing Home Staffing Measures
  Having a consistent and high performing workforce is a critical contributor to quality care. Appropriate staffing levels and reduced staffing turnover are generally associated with fewer hospitalizations, infections, and pressure ulcers, and higher levels of improved functional status. Multiple staffing criteria associated with increased quality of care should be included in the measures selected.

- Quality of Life Measures/Satisfaction
  The Workgroup and provider community believe that resident and family satisfaction is an important component of a good P4P program and must therefore be included. Many nursing homes utilize survey tools to assess resident, family, and employee satisfaction in order improve the quality of services provided in their facilities. There are multiple quality improvement tools available from vendors to assess resident and family satisfaction, and a subset of those survey instruments have undergone extensive testing and development. It is recommended that a review of products to assess resident and family satisfaction be conducted in order to identify the appropriate survey instrument and/or the set of satisfaction measures to include in the Commonwealth's P4P program.

- State Survey/Inspection Deficiencies
  It is recommended that survey deficiencies be included as a part of the performance assessment. Facilities should meet a pre-defined minimum level during the state survey inspection process in order to qualify for the P4P payment rewards. Although there is debate over the shortcomings of the state survey process to measure quality and satisfaction, it is important that survey deficiencies are included as a factor in the performance measurement. It would not be desirable to have a facility receive a reward when the facility performs poorly on an inspection survey.

- Other measures to consider
  Avoidable hospitalization rates among nursing home patients are a concern for policy makers and providers alike, as they are associated with higher costs and poorer quality. The QTP Workgroup recommends considering solutions to improve avoidable hospitalization rates; however, the Workgroup notes that this is a more sophisticated recommendation that would be difficult to implement in the first phase of the P4P program. Therefore, the Workgroup recommends that as the program progresses and shows success, avoidable hospitalization rates should be revisited and eventually included as a component of the program.

  In addition, there may be other potential performance measures not captured in the aforementioned categories. Organizational metrics focused on concepts like culture change or person-centered care should also be considered for inclusion in the measurement scheme. Culture change or person-centered care organizational models are aimed at improving quality of life and care for residents and the quality of the work environment for staff at facilities. Many models for these concepts exist and have been increasingly incorporated within the nursing home industry. Although metrics for culture change or the level of person-centered care are a new area under development, it maybe useful to identify promising models and include measures as deemed appropriate.

- *The Governor, through the Secretary of Health and Human Resources, should require the Nursing Home P4P program incorporate, at a minimum, MDS, staffing, satisfaction, and survey criteria into the measurement components for quality. Additionally, the Governor should also require the Nursing Home P4P program be updated, modified, and improved over time to include additional metrics targeting specific areas the Commonwealth would like to address, such as avoidable hospitalization rates.*

Incentive Structure

Both non-financial and financial incentives should be used to create the P4P program. Non-financial incentives can be used to pilot test measures before transitioning effective measures to a financial reward system. The choice of measures and design of incentives will require careful consideration in order to minimize or avoid incentives that would lead to gaming of the system or that would deter facilities from admitting difficult residents that may lower their performance scores; care must be taken in the design of incentives.

Funding for the financial incentives should be above and beyond current reimbursements in order to fund rewards to "high performers;" poor performers should not be penalized by withholding payment. It is important to maintain a level of reimbursement that encourages a basic standard of quality care through current Medicaid payment policies. Given that facilities may be operating near or at costs, reducing payments through penalties may lead to poorer quality of care or facility closure. Overall, the incentive structure should be designed to reward innovation, modernization and culture change that promote quality in resident care.

- *The Governor should require that funding for the Nursing Home P4P program come from new monies and that the program incorporate both financial and non-financial incentives. Overall, efforts should be made to reward innovation, modernization and culture change that promote quality in resident care.*

Evaluation Component

It is recommended that a well designed evaluation component be created alongside the development of the P4P program. Given that little evidence in literature exists regarding the effectiveness of P4P systems for Nursing Homes, a well developed and executed evaluation would assist in capturing whether rewards can promote the quality of resident care and whether inadvertent consequences result. Monitoring is necessary to determine the effects of financial incentives on quality of care and the impact of the program on facilities and their residents. Evaluation and outcome measurement should at a minimum occur every other year, with a report due to the Secretary of Health and Human Resources.

- *The Governor, through the Secretary of Health and Human Resources, should require the Nursing Home P4P program be evaluated and monitored regularly to assess effectiveness, with an annual report due to the Secretary of Health and Human Resources.*

Consumer Outreach: Public Reporting of Scores

In order to increase transparency between consumers and nursing care facilities, efforts should be made to publicly report performance scores collected through the P4P initiative. The development of a consumer-friendly website to display scores, rankings, or other performance data collected can be valuable for consumers to compare and select facilities. Furthermore, public reporting of performance scores via a website or other accessible means provides additional impetus for nursing facilities to attain or exceed quality targets in order to attract residents to their facilities. DMAS should work with Virginia Health Information (VHI) to discuss the options for the inclusion of performance data into the web-based information portal recommended in the QTP Workgroup's transparency report. Publicly reporting performance scores among participating nursing homes places an additional decision-making tool in the hands of the consumer.

- *Quality performance scores should be made publicly available through a website or other accessible means in order to increase transparency between consumers and nursing facilities and also provide consumers with an additional tool to compare and select*

nursing facilities. DMAS should discuss with VHI options for including such data as part of the information portal recommended in the transparency report.

As directed by legislative mandate, efforts by DMAS are underway to begin the development of a Medicaid Nursing Home P4P proposal. DMAS has identified and gathered together a stakeholder workgroup with state, industry, and consumer representation to begin the planning process. It is recommended that DMAS and the taskforce of key stakeholders continue to collaborate to further develop the Medicaid nursing home P4P program structure and components. States that have done well have used an inclusive process in the development of strategies that involve many partners and consumer representatives. The QTP Workgroup would ask that DMAS and its stakeholder workgroup follow the recommendations as outlined and discussed in this report. The QTP Workgroup would also recommend the Governor consider these recommendations when evaluating the proposal developed by DMAS's workgroup and developing his final proposal. Finally, the DMAS stakeholder workgroup should keep the Health Reform Commission and staff informed about its process and final recommendations.

AWARENESS OF CONCERNS

There are a number of concerns to consider and account for in the design of a P4P program. The design of the P4P program should include steps to:

- Ensure the appropriateness of incentives to reward quality (i.e., link the measure and incentive to quality outcomes).
- Deter gaming of the system and adverse selection, as these may lead to decreased access to care, increased disparities, or impediments to innovation.
- Avoid incentives that will only produce improvements in documentation rather than actual quality of care provided to nursing home residents.

Additionally, questions surrounding the optimal design, effectiveness, and implementation of Medicaid nursing home P4P programs remain due to lack of definitive evidence. However, Virginia can contribute towards pilot-testing efforts to align payment polices with quality improvement in this arena. The evaluation component of this initiative will be an important one, as it will provide a mechanism to assess indicators, provide feedback to help to shape the program, and perhaps lead towards the contribution of national indicators. The intent of overall program should be to encourage quality improvement and dissemination of best practices.[143]

ESTIMATED COSTS

Based from other state program, the incentive payment budget is generally 1-2 percent of reimbursement rates. In Virginia, this would equate to $7-8 million or $14-16 million. More research on the effectiveness of incentive size is needed before justifying larger incentive payment budget.

[143] Dow, A. (2004). *Issues to Consider in Implementing a Pay-For-Performance Program.* A Report by the Office of the Auditor for the Metro Council. Portland, OR.

BACKGROUND – TRANSPARENCY

Over the last decade, there has been a drive for increased transparency and accountability in the healthcare sector, yet pricing and quality often remain a mystery to most consumers because access to these avenues is limited. It is difficult for consumers to maneuver and an accurately evaluate healthcare options available to them. This is due to the complex nature of the pricing system found in the sector. When discussing healthcare pricing, charges are often discussed, yet most people do not pay based upon charges. For those with insurance, their insurer may have negotiated a specific discount on the charges, or may pay based on a percent of charges, a per diem rate, or another negotiated rate. For those without insurance, most providers are working to provide similar discounts or care is provided for free. This makes pricing transparency extremely challenging because providing information on charges does not really mean anything to most consumers, and asking insurers and providers to provide a detailed map of what is actually paid gets at the heart of contract negotiations and may be considered proprietary information. Despite this, it will be necessary to navigate these complexities and create a path towards a transparent system in order to increase consumerism in healthcare[144]

In addition, defining transparency and its intent has often been a challenge. Simply presenting cost information may not be that meaningful to consumers. Consumers need information that helps them understand their financial obligation for an episode of care, not just a procedure. In addition, quality information must be a part of the equation or consumers may be driven to go to the highest cost provider, assuming that higher cost means better quality. The converse could also happen, i.e. the consumer could opt for lowest cost provider with no information on the quality of the provider. In essence, being transparent on prices does not mean much if that pricing is not put into context with quality and episode of care information.[145]

The push for transparency is occurring for many reasons including a greater focus on increased consumerism and personal responsibility in healthcare. This has been evidenced through the development of high deductible health plans, health savings accounts, and higher co-pays and co-insurance. In addition, the rising costs and inflation rates seen in healthcare indicate that something must be done or the "system" we currently have will not be maintained. Pricing, quality, and information transparency is believed to be one method that could begin to help control in costs.

In August of 2006, President Bush signed an Executive Order (EO), which clearly defined the federal government's intent and definition of transparency. In December of 2006, Governor Timothy M. Kaine issued an EO similar to President's Bush's, EO 42. The Commonwealth of Virginia was the first state to join the federal government in this initiative. The Commonwealth's goal is to help consumers and other stakeholders make value-driven healthcare choices by improving the availability of sound and useful information and collaborating with ongoing government and private sector efforts in this regard.

EO 42 focused on four areas: promoting the adoption of interoperable Health Information Technology, Transparency of Quality, Transparency of Pricing, and Promoting Quality and Efficiency of Care. Each of these areas is described in further detail in Table 1.

Table 1: Description of EO 42 Focus Areas

Focus Area	Description
Health Information Technology	The Commonwealth will work with health insurance providers or third party administrators to encourage these companies to use health information technology systems and programs that meet interoperability standards recognized by the Secretary of Health and Human Services as existing at the time the systems are updated or implemented. In exchanging information, patient privacy will be protected as required by law.

[144] Clarke, L. (2007). Frontiers of Health Services Management. *Pricing Transparency: Building Community Trust.*

[145] Blue Cross Blue Shield Association (2006). *Consumer Preferences and Usage of Healthcare Infocrmation Summary Report.*

Transparency of Quality	To support assessment of the quality of care delivered by healthcare providers, the Commonwealth will encourage health insurance providers or third party administrators with which it contracts, to implement programs measuring the quality of services supplied to their enrollees. The Commonwealth will play an active role in bringing multiple stakeholders together to develop appropriate metrics for use in Virginia. Quality measurements will be developed in collaboration with similar initiatives in the private and public sectors.
Transparency of Pricing	To support consumer knowledge concerning the cost of care, the State Employee Health Benefits Program will work with its third party administrator(s) to make available to enrollees in state-sponsored health insurance plans the prices paid to providers for healthcare procedures, drugs, supplies, and devices. The Commonwealth will also participate with multi-stakeholder groups in developing information about the overall cost of services for common episodes of care and the treatment of common chronic diseases.
Promoting Quality and Efficiency of Care	The Commonwealth will examine appropriate opportunities to promote pay for performance in healthcare financing, consistent with its goals of maintaining access, a broad provider network, and quality health services. These efforts will focus on chronic disease management. We will also work with our federal and private sector partners to identify opportunities to improve the quality and safety of care across the board, with a particular focus on management of chronic diseases.

Transparency and its Effects on Virginia

Virginia's healthcare system has many strengths; from state of the art hospitals and treatment centers to highly trained and dedicated healthcare professionals. Virginians also point with pride to many public and private efforts to improve access to healthcare and make it more affordable to those most in need.

Despite these successes, Virginia businesses and consumers face rising healthcare costs and differences in the quality of care provided. An ever-growing number of Virginians are paying more for healthcare through increased co-payments, deductibles, and premiums. Consumers want and need information to help them make more informed healthcare purchasing decisions. [146]

Fortunately, the Commonwealth and a variety of healthcare stakeholders already sponsor and support a "*home*" for a variety of consumer healthcare information. Virginia Health Information (VHI), a nonprofit organization established by the General Assembly in 1993, collects and publishes information on Ambulatory surgical centers, HMOs, hospitals, long-term care providers, and physicians. VHI's website hosts more than a quarter-million visitors annually. Despite this, the web site needs some improvements to make it more consumer friendly.

Given this existing platform for health information, stakeholders have presented their desire for a VHI-administered consumer health information portal to VHI's Board of Directors. These stakeholders also recognize the growing availability of information on healthcare quality and pricing from health insurance companies, government sponsored programs, and private sources. Presently, many health insurers in Virginia are expanding information available to those enrolled in their health insurance plans. Most insurers have a variety of online tools for consumers including:

- *Directories:* Locate doctors and hospitals near you, shows hospital quality ratings, and checks cost estimates for medical services and prescription drugs.
- *Health Tools*: Learn how to stay healthy, deal with an illness, or prepare for a surgical procedure, including questions to ask your doctor.

In addition, many insurers are using online tools to inform consumers about expected out of pocket costs and quality information. The insurers are not the only segment of the industry working on transparency. CMS, Boards of Medicine, Hospital Associations, and non-profits also provide information on costs,

[146] Blue Cross Blue Shield Association. (2006). *Consumer Preferences and Usage of Healthcare Infocrmation Summary Report.*

quality, and other information. See Table 2 for more information on the transparency initiatives currently taking place across the Commonwealth and the country.

Table 2: Transparency Initiatives[147]

Insurer	Transparency Initiatives/Data Available
Anthem	• Information on a number of procedures • Compare hospitals on procedures • Range of hospitals charges for a specific procedure
Aetna	• Physician specific information on pricing
Cigna	• Average cost data by facility for 15 outpatient procedures and 3 high cost radiology services (pilot program in New Hampshire and Wichita)
Definity (United)	• Physician quality and efficiency designations • Price range for specific treatments across hospitals and facility quality ratings for those treatments • Determine and compare the cost of medications at different pharmacies in their area and use a Savings Advisor tool for recommendations on how to reduce their overall pharmacy costs • Pricing for specific procedures or services based on their zip code
Lumenos (Wellpoint)	• Demographic information about the physician – education, years in practice, specialties • Physician rating – what other consumers have said about the physician • Physician specific information on pricing
Optima Health	• Estimate the cost of services – Expected payment for a wide range of services, including prescription drugs, physician office visits, diagnostic tests like MRIs and CAT scans, and lab tests. • Estimate the cost of treatment for a condition such as a chronic illness – Estimates include the services used most for each condition, including outpatient services, medications, and primary care and specialist visits.
Southern Health	• Average unit cost comparison
CMS	• Quality information available on ambulatory surgical centers, diagnostic centers, home healthcare, hospitals, and nursing homes
Virginia Board of Medicine	• Demographic information about the physician – education, years in practice, specialties and malpractice information
Virginia Hospital and Healthcare Association	• Most common reasons for hospitalization • Price information (charges) for procedures • Payor mix • Hospital financial assistance information
Leapfrog	• Works with employer members to encourage transparency and easy access to healthcare information • Rewards hospitals that have a proven track record of high quality care
VHI	• Outpatient surgical information for 7 groups • Quality information on all types of cardiac care, HMOs, nursing facilities, and physicians • Financial and operational information from ambulatory surgical centers, hospitals, nursing homes • Licensure data

Unfortunately, as evidenced by Table 2, this information is spread all over cyberspace. This makes finding and using this information difficult and time consuming. Therefore, what Virginia lacks is a p*ortal* or *clearinghouse* to simplify access to consumer healthcare information from many locations. Such an approach is attractive as it:

[147] Gray, D. (2006). *Health Plan Transparency.* Virginia Association of Health Plans.

- Creates a one-stop-shop for access to information
- Avoids duplication of efforts by leveraging existing information
- Can gather and display information most relevant to a consumer's needs
- Would provide information on pricing and quality to persons without health insurance
- Would provide easy access to Medicare, state sponsored information, and commercial health insurance information for those covered by those programs

GOAL

In order to determine where next to take pricing transparency in the Commonwealth, an overarching goal was defined as follows:

> *Fostering a system to provide easily accessible and reliable information on healthcare costs and quality to improve the healthcare literacy of patients, providers, and employers and to stimulate provider behavior to improve healthcare for the citizens of the Commonwealth.*

This goal should be the foundation for developing the portal or clearinghouse. In order to improve consumerism in healthcare, it is imperative to not only provide information but also education. With a system as complex as the U.S. system, simply providing information will not do for most consumers.

RECOMMENDATIONS

Recommendations have been made around various topics that the Quality, Transparency, and Prevention Workgroup feels are important to ensuring the success of any transparency efforts in the Commonwealth.

One Portal

VHI should serve as the portal or clearinghouse for transparency information for the Commonwealth. All of the stakeholders agree this would be the best arrangement given VHI's extensive data gathering capabilities and established role in health data reporting. The stakeholders did note that the portal should build on and incorporate what has and is already being done across the healthcare sector. In addition, the Workgroup recommends that the VHI portal be redesigned to be more intuitive and understandable to the average consumer. Finally, when developing the portal, standards for the types of information allowed on the portal must be developed; otherwise, chaos and the legitimacy of the portal could be in jeopardy.

To create this type of portal, the Workgroup recommends that the Health IT Council be directed to assist VHI and key stakeholders to provide input and expertise to fully develop the structure and look of the consumer-friendly portal. Potential key stakeholders would include, but not be limited to, VHI's executive director, VHI's board, the Virginia Hospital and Healthcare Association (VHHA), the Virginia Association of Health Plans (VAHP), the Virginia Health Care Association (VHCA), the Department of Medical Assistance Services (DMAS), the Virginia Department of Health (VDH), and members of the business community. VHI, the Health IT Council, and key stakeholders would more than likely need to add or work with some experts and/or technical advisors from the field while developing the portal. VHI would continue working with its existing task force and stakeholder groups to expand the content provided on the new, consumer-friendly portal.

The Workgroup also recommends that metrics be assigned to determine the effectiveness of the portal. This could include, but not be limited to, number of hits per year, number of consumer hits per year, number of repeat visits, most sought after/used information, number of clicks to get to information, user-friendliness, accessibility, etc. VHI, the Health IT Council, and the stakeholder group would be charged with developing the appropriate metrics.

- *The Governor, through the Secretary of Health and Human Resources and the Secretary of Technology, should direct the Health IT Council to assist VHI and key stakeholders to develop and implement a single portal for the dissemination of useful, transparent information on healthcare costs and quality to consumers.*

Quality

There is currently a lack of information on quality, which is essential for a transparency portal to be valuable to the consumer. Without quality information, the portal could unintentionally drive consumers to higher priced providers. In September 2004, the American Academy of Family Physicians (AAFP), the American College of Physicians (ACP), America's Health Insurance Plans (AHIP), and the Agency for Healthcare Research and Quality (AHRQ), joined together to lead an effort for determining how to most effectively and efficiently improve performance measurement, data aggregation, and reporting in the ambulatory care setting. This group is known as the AQA alliance. The AQA alliance has made efforts to move transparency forward and make it operational. Currently, six pilot projects will combine public and private information to measure and report on physician practice. The vision is to have six different strategies and then begin to develop a consensus among them.

The Medical Society of Virginia, VHI, Virginia Business Coalition on Health, Virginia Health Quality Center, VAHP, and the VHHA, have come together to form the Virginia Healthcare Alliance (Alliance). The mission of the Alliance is to foster a coherent, efficient, and integrated framework of performance measurement and reporting; aligning with both Secretary of Health and Human Services Michael Leavitt's four cornerstones of Value-Driven Healthcare and Governor Timothy Kaine's Executive Order for state-funded healthcare price and quality information geared to help consumers make more informed healthcare purchasing decisions.

The Alliance plans to apply for federal *Community Leader* status. The term *Community Leader* reflects a determination by the U.S. Secretary of Health and Human Services that an organization is willing, capable, and likely to succeed in implementing the four cornerstones:

1. Public reporting of quality of care
2. Public reporting of the cost of health services
3. Interoperable health information technology, and
4. Incentives for achieving better value in healthcare

- *The Governor, through the Secretary of Health and Human Resources, should seek to use the best practices identified by the AQA alliance and support efforts by the Virginia Healthcare Alliance to obtain AHRQ grants to develop Virginia's quality measures.*

Pricing Information

Determining the true pricing of services is a challenge in the healthcare sector. Providing information on charges is not valuable to most people. However, sharing an insurer's negotiated discounted rates is not plausible. Therefore, the Workgroup recommends that VHI work with the insurers to show a price range for each procedure by insurer within a geographic region. The Workgroup also believes the portal should then provide links to each insurer's website so that the consumer can get information that pertains to their specific insurance product. For those who are uninsured, the Workgroup recommends the portal display financial information for each provider as available. This financial information would preferably not be based on charges, but on discount rate ranges. In addition, the state should provide both Medicaid and state employee insurance pricing data to VHI.

Another issue with pricing information is that providing the price for just one procedure is often not enough information for the consumer. What consumers really need is pricing information for an episode of care. The Workgroup recommends that VHI, over time, develop episode of care information as appropriate. The Workgroup also recommends that until episode of care

information is readily available, VHI should focus on outpatient services and those services whose episode of care might only be one or two procedures.

- *The Governor should assure, either administratively or through appropriate legislative action, that public and private payors provide to VHI, for use on the new transparency portal as appropriate, a reasonable range of amounts paid by the payor for specific procedures by geographic areas within the Commonwealth.*

- *The Governor should direct the Secretary of Health and Human Resources to convene a stakeholder group to work with VHI and the Health IT Council to determine the best method for securing the appropriate and most useful pricing information from public and private payors.*

Health Literacy

In addition to the portal providing pricing and quality information, the portal should also aim to improve the health literacy of all citizens of the Commonwealth. The Workgroup noted that most people not in the healthcare industry have a minimal understanding of how the "system" works because of the complexities that are unique to healthcare. Therefore, the Workgroup recommends the portal also be used as a way to disseminate reliable healthcare information. This would include, but not be limited to:

- What is insurance and how to obtain insurance
- How to obtain insurance for a small business
- What is Medicaid and how to qualify
- What is Medicare and how to qualify
- How to learn about a provider's financial policies on costs for uninsured patients
- How to get information on other healthcare topics including chronic disease information, long-term care, prevention, etc.

- *The Governor, through the Secretary of Health and Human Resources and the Secretary of Technology, should direct that the new transparency portal include general healthcare information and links to other important sites for information, in order to create a true one-stop-shopping portal for Virginians to access important healthcare information.*

Marketing

In order to change how consumers behave they not only have to be given the tools, but they must be aware the tools exist. Therefore, the Workgroup strongly recommends developing and implementing a marketing plan that interfaces with all segments of the community from consumers to providers (hospital, physicians, nurses, nursing facilities, assisted living facilities, etc.) to insurers to employers. To do this a full-blown marketing campaign would need to go into effect including, but not limited to, public service announcements, commercials, newspaper ads, brochures, pamphlets. An evaluation will be conducted of the value of adopting a "catchier" website name while avoiding potential loss of the existing base of approximately 1,000 daily visitors.

- *The Governor should direct the Secretary of Health and Human Resources, working with VHI, key stakeholders and state agencies, to develop and implement a public-private marketing plan to make Virginians aware of the new transparency portal and the valuable healthcare information that can be accessed through the VHI portal.*

Accessibility to the Portal

It is imperative that the portal is accessible to all citizens of the Commonwealth, including but not limited to those with disabilities, those who are not yet proficient in English, those with limited reading skills, and those who do not have access to the internet. The Workgroup recommends that in order to create a portal that is accessible to all; the Health IT Council includes a representative from the disability community. In addition, the Workgroup recommends that after the initial launch of the portal subsequent phases should seek to provide information in various languages and increase accessibility to the portal. Finally, the Workgroup realizes that not everyone has access to the internet; therefore, information should be made available in brochures, pamphlets, phone line, etc. The 211 line and/or VHI's toll free line could be expanded to include providing information from the portal to consumers.

Accessibility also includes the readability and usefulness of the portal to the average consumer. While the topic of healthcare pricing, quality, literacy, etc. is challenging to understand, it must be conveyed at a level that all citizens of the Commonwealth can understand. VHI should continue its current endeavors to improve its website.

- *The Governor, through the Secretary of Health and Human Resources and the Secretary of Technology, should direct the Health IT Council to assist VHI in ensuring that the portal developed in conjunction with VHI and key stakeholders is accessible to all Virginians.*

ESTIMATED COSTS

The VHI projects costs based on current expenditures for data processing, programming, and the use of their existing infrastructure. The first year funding request of $157,250 reflects the initial research, analysis, development, design, and implementation of revised consumer information. These include the new quality indicators on hospitals, nursing facilities, and home healthcare facilities. In addition, these funds cover initial development of top surgical procedures. The second year budget request of $147,500 is less than the first year since much of the initial research and design will be completed and related costs will be lower. There will be continued updating of information in both the second and third years, with the third year request of $150,000 reflecting ongoing development, implementation of new information and maintenance and enhancements of consumer information based upon feedback and evaluation. Therefore, for three years the total estimated cost to create the portal is $454,750. It should be noted that does not include a marketing plan and the insurer information required in this proposal.

PROMOTING PREVENTION

Virginia is a successful and highly competitive state in many areas. Virginia is ranked as the 7th highest state in per capita income.[148] In 2007, *Education Week* ranked Virginia as the state where "a child is most likely to have a successful life."[149] In addition, the Commonwealth has an attractive business climate, being named the Best State for Business by *Forbes Magazine* in 2006 and 2007.[150] Despite this, the overall health status of the citizens in the Commonwealth does not mirror these other accomplishments.

In 1998 Virginia was tenth overall among the states in health rankings. Since 1998, Virginia's overall health rankings have declined. The following chart displays the steady down turn in the Commonwealth's ranking compared to the other fifty states:

Table 1: Virginia's Overall Health Ranking Among the Fifty States (1998 – 2006)[151]

Year	Rank	Year	Rank
1998	10	2003	21
1999	14	2004	20
2000	14	2005	24
2001	15	2006	21
2002	18		

Virginia's ranking has been fluctuating since 2003. This inconsistency is unacceptable. Virginia must promote reforms in preventative care as part of its journey to reclaim a spot among the top ten healthiest states. The quality of health, specifically reducing the infant mortality rate, the prevalence of obesity, and the use of tobacco, must be improved. Virginia was ranked 33rd in the nation in 1990 and 32nd in 2006 for its infant mortality rate. The Commonwealth has remained steady in this category; however, due to increased access to prenatal care and the economic status of the state, infant mortality should be waning at a much more significant rate. In 1990, Virginia ranked 9th in the prevalence of obesity, but has dropped substantially to 28th in 2006. In 2005, Virginia was the 24th most obese state and managed to drop four rankings in just one year. The obesity epidemic is widespread and adversely affecting the quality of health in the Commonwealth. Finally, in 1990 Virginia ranked 42nd in prevalence of smoking and in 2006 has dropped to the 25th position for tobacco use. This is an area where Virginia has made substantial progress over the past fifteen years, but there is still much to be done.[152]

Virginia is a leader among the states in many areas. The vision for the Commonwealth is to be consistently ranked in the top ten healthiest states for the overall ranking. In 2004 and 2005 the infant mortality rate in Virginia was 7.4 deaths per 1,000 live births. The goal is to reduce this to 7.0, a 5 percent reduction in infant deaths, by the end of FY 2009. In 2004, 24 percent of Virginians were obese and the goal is to reduce this number to a maximum of 20.5 percent, a 15 percent reduction, by the end of FY 2009. In 2006, Virginia was ranked 25th for tobacco use with 20.6 percent of adults over the age of eighteen smoking. By the end of FY 2008, Virginia should refuel its efforts to reduce its adult smoking rate to 19 percent and its youth smoking rates to 14.5 percent.[153]

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[148] U.S. Census Bureau. (February 2006). *State Rankings – Statistical Abstract of the United States*. Retrieved on June 27, 2007, from: http://www.census.gov/statab/ranks/rank29.html.

[149] Education Week. *From Cradle to Career*. Retrieved August 2, 2007 from: http://www.edweek.org/media/ew/qc/2007/17shr.va.h26.pdf

[150] Badenhausen, K. (2007). *The Best States for Business.* Retrieved August 2, 2007, from: http://www.forbes.com/2007/07/10/washington-virginia-utah-biz-cz_kb_0711bizstates.html.

[151] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

[152] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

[153] United Health Foundation. *America's Health Rankings.* Retrieved July 25, 2007, from: www.unitedhealthfoundation.org.

The Prevention section of the Health Reform Commission (Commission) Report covers at length the three areas, infant mortality, obesity, and tobacco use, reviewed by the Commission. There is a segment dedicated to each of these areas. Each segment includes information regarding the national effects of infant mortality, obesity, and smoking, the effects they have on Virginia, and why the Commonwealth should pursue policy change to address these concerns. Each section ends with recommendations that the Commission believes the Commonwealth should begin implementing.

OVERALL PREVENTION RECOMMENDATION

The Quality, Transparency, and Prevention Workgroup (QTP Workgroup) of the Health Reform Commission (Commission) developed a recommendation that would apply to prevention services throughout the Commonwealth. Initially this recommendation would focus on the three areas the QTP Workgroup focused on, infant mortality, obesity, and tobacco use. However, it could be expanded to focus on all prevention services in the Commonwealth over time and as appropriate.

The recommendation is to establish a non-profit collaborative that would be charged with the goal of creating a healthier population in the Commonwealth such that Virginia would be ranked among the top ten healthiest states in the nation by 2010. The focus of the non-profit collaborative would be to 1) promote greater use of clinical preventive services throughout Virginia's healthcare delivery system and 2) promote healthy lifestyle choices throughout the Commonwealth. The non-profit collaborative would be responsible for fostering collaboration among employers, health plans and other payors for healthcare services, healthcare providers, public health, public education, and other public and private stakeholder groups. The non-profit collaborative would foster collaboration through, among other means, leveraging of public and private funds. The non-profit collaborative would be governed by a board that would include key public and private stakeholders. Finally, the collaborative would have a reporting relationship with the Virginia Department of Health (VDH) and would require some initial start-up funding.

- *The Governor should establish a non-profit foundation that will leverage public and private funds to focus on promoting clinical preventive services and healthy lifestyle choices across the Commonwealth.*

ESTIMATED COSTS

Table 2: Pricing of Overall Prevention Recommendations (Annual Estimated Costs)

Establish a non-profit collaborative that will leverage public and private funds to focus on promoting clinical preventive services and healthy lifestyle choices across the Commonwealth	$ 5,000,000

The National Effects of Infant Mortality

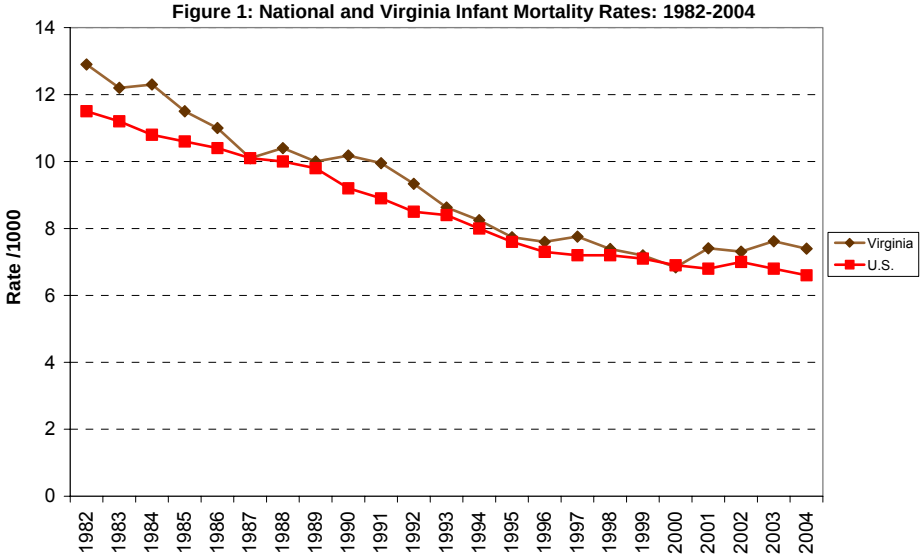
A significant indicator of a nation's health status and the social well being of a population is the infant mortality rate (IMR), which is defined as the number of deaths per 1,000 live births during the first year of life.[154] Generally there is a correlation between the economic wellbeing of a country and the infant mortality rate, with poorer nations having higher infant mortality rates. The United States is the most affluent country in the world, yet 37 countries had a lower IMR in 2005.

Over the past 50 years infant mortality has steadily declined because of better prenatal care, new technologies, evidence-based medical treatment, and improved health education. There has been a slight increase in these rates over the past five years, in part due to the rise in preterm and low birth weight rates. The national IMR has not improved for several years remaining at 6.9 deaths per 1,000 live births. The Healthy People objective for 2010 is to reduce the IMR to 4.5 deaths per 1,000.[155]

Infant Mortality and Its Effects on Virginia

The IMR in Virginia was 12.9 infant deaths per 1,000 live births in 1982 and has since been on a downward trend. Virginia has consistently had a higher IMR than the national average for all but one of the past 22 years. Currently, the IMR in Virginia is 7.4 infant deaths per 1,000 live births. An IMR greater than the national average is not acceptable for a state with steady economic growth, a solid healthcare system and leaders in the medical field.[156] Similar to the discrepancies between the United States' financial well being and its universal IMR ranking, Virginia's economic success is not accurately reflected by the higher than average IMR.

Figure 1: National and Virginia Infant Mortality Rates: 1982-2004



Source: Virginia Department of Health, Division of Health Statistics

Environment and Cultural Forces Driving Infant Mortality Rates

The primary causes of infant death are prematurity and low birth weight, birth defects and congenital malformations, Sudden Infant Death Syndrome (SIDS), and other general problems associated with the complications of pregnancy. Birth defects and congenital malformations are the leading cause of infant death for Caucasians; whereas, extreme prematurity is the primary cause of infant deaths for African Americans.[157]

[154] Virginia Department of Health, Office of Family Health Services.

[155] Health People 2010. Retrieved August 10,2007 from: http://www.healthypeople.gov/document/HTML/volume2/16mich.htm

[156] Virginia Department of Health, Office of Family Health Services.

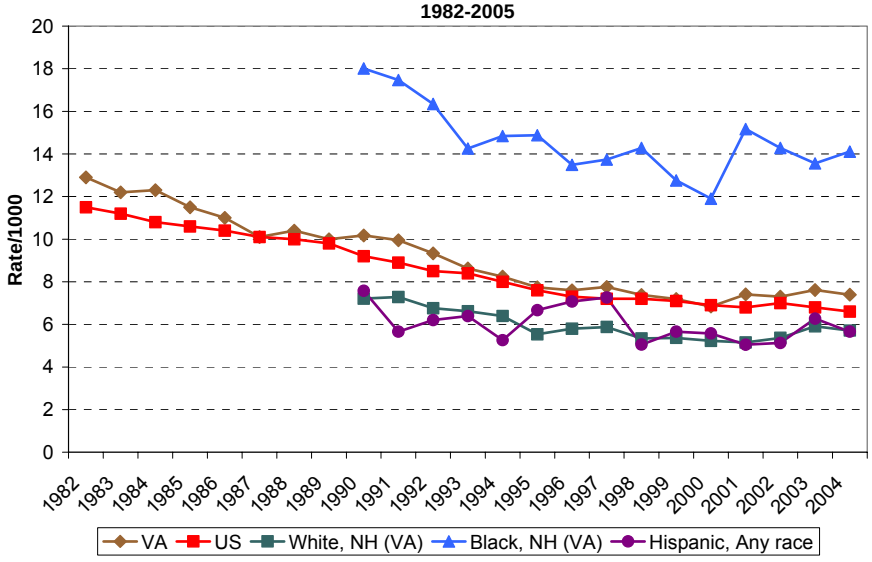
[157] Virginia Department of Health, Division of Health Statistics.

Factors associated with infant death can often be linked to maternal behaviors and lifestyle choice including poor nutrition, lack of prenatal care, smoking, and substance abuse.[158] In 2003, 19.3 percent of the women in Virginia of childbearing age were obese and 20.2 percent were smokers. The lifestyle choices of these women significantly diminish their chances of having healthy babies.[159] In addition to behavior and lifestyle choices, women who possess minimal formal education, limited income and access to prenatal care, elevated levels of stress, are unmarried, depressed, or have an absence of family and community support are more likely to lose their babies during the first year of life. Finally, Virginia is without a comprehensive coordinated system of care, which can create additional obstacles that prevent women from having healthy, full term babies. There are approximately seven million residents in Virginia, one million of which do not have access to health insurance. Many of the uninsured Virginians are expectant mothers. Without adequate care and resources, these women are at a greater risk of not carrying their babies to term or having a child of low birth weight.[160]

Infant Mortality Race Disparities in Virginia

Virginia's IMR for babies born to African-American women is consistently higher than that of infants born to women of other races. Relative to white women, infants born to African-American women are approximately twice as likely to die prior to their first birthday. In 1990, the IMR for African-Americans was 18.0, in comparison to 7.2 deaths per 1,000 live births for the white population. The IMR has declined for both of these populations, and in 2005 there were 14.3 African-American and 5.9 white deaths per 1,000 live births. It is apparent that both races have seen a substantial decline in the IMR, but the disparity between African-Americans and whites persists.[161]

Figure 2: National and Virginia Infant Mortality Rates by Race and Ethnicity: 1982-2005



Source: Virginia Department of Health, Division of Health Statistics

Resources to Reduce Infant Mortality Rates

Community-based home visiting has become a useful approach to improving birth outcomes. As of 2001, home visiting programs existed in 37 states and have become more numerous in recent years. Home visiting programs vary in their goals and curriculum, target population, and outcome measures.[162] "The method of delivering the service or intervention to families in their own homes offers advantages in that parents do not have to arrange transportation, child care, or time off from work. Bringing the intervention into the home also provides an opportunity for more whole-family involvement, personalized service, individual attention and rapport building. These factors not only aid the family but may also increase

[158] Virginia Department of Health, Office of Family Health Services.

[159] March of Dimes. *Born Too soon and Too Small in Virginia*. Retrieved June 23, 2007, from: http://www.marchofdimes.com/peristats/pdflib/195/51.pdf.

[160] Virginia Department of Health, Office of Family Health Services.

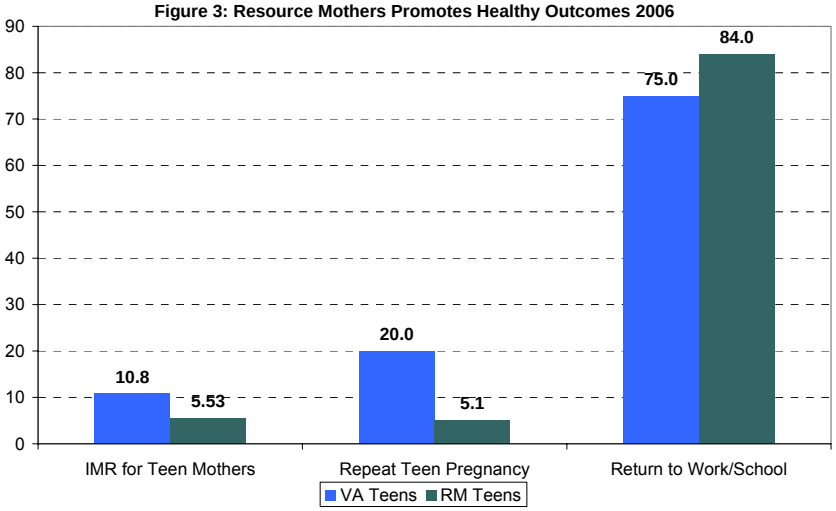
[161] Virginia Department of Health, Division of Health Statistics.

[162] Gomby, D.S. (July 2005). Home Visitation in 2005: Outcomes for Children and Parents. *Invest in Kids Working Paper Number 7.*

program retention rates."[163] The staff of home visiting programs can be comprised of dieticians, social workers, nurses, and community health workers. The target population for home visits varies based upon program goals. For example, some at home initiatives direct their resources towards education and preparation for the expecting mother during the prenatal period, while others work with the mothers after the infant's birth to foster a healthy living environment for the newborn. In addition to monitoring birth outcomes, at-home programs assess health status of the mother, security of the living environment, encourage healthy maternal health behaviors, self-sufficiency, and promote healthy parenting practices.[164]

The Resource Mothers Program is a community-based home visiting initiative founded in 1984 to serve pregnant teenagers throughout the Commonwealth with the intent of decreasing the rate of infant death and low birth weight rates. Since its inception, the program has served approximately 20,000 pregnant teenagers. Figure 3 shows that teens in Resource Mothers have better outcomes than those who are not. The resource mother is a community health worker who mentors a pregnant teen. Young women enter this home visiting program as early as the first trimester and remain an active participant until the infant's first birthday. The program has two major components, increasing early and adequate prenatal care and encouraging a healthy lifestyle for both the mother and the newborn.[165]

Figure 3: Resource Mothers Promotes Healthy Outcomes 2006



Source: Virginia Department of Health, Office of Family Health Services
Note: IMR is per 1,000 live births; Return to work and/or school by infant's first

Another community-based home visiting program is the Comprehensive Health Investment Project (CHIP) of Virginia. CHIP of Virginia has partnered with 30 Virginia localities to assist low-income families from childbirth until age six. The home based team is comprised of a registered nurse and a community health worker. CHIP's primary goals are to ensure that children from low-income families receive necessary healthcare in order to live healthy lives and start school prepared to learn. Chairman David Levin states that "After a year in CHIP, more than 90 percent of all CHIP children are up to date on their immunizations, have health insurance and a medical home, and know how to effectively use the healthcare system. Their parents understand their role in preparing their children for school and how they can promote early learning."[166]

The National Healthy Start Program, funded by the Health Resources and Services Administration, began providing services to women at high risk of infant death and low birth weight in 1991. The Richmond Healthy Start Initiative (RHSI) has received funding since 1994 with the Loving Steps program (Virginia Healthy Start Initiative) following in 1997. Based on the premise that community-drive strategies are needed to address factors contributing to infant mortality, low birth weight, and other adverse perinatal outcomes in high-risk populations, Healthy Start projects focus on improving maternal and child health

[163] Sweet, M.A. and Appelbaum, M.I. (2004). Is Home Visiting an Effective Strategy? A Meta Analytic Review of Home Visiting Programs for Families with Young Children. *Child Development*, 75 (5).

[164] Virginia Department of Health, Office of Family Health Services.

[165] Virginia Department of Health, Office of Family Health Services.

[166] CHIP of Virginia. *What is Chip?* Retrieved June 29, 2007, from: http://www.chipofvirginia.org/pdf/AR2006.pdf.

outcomes by increasing access to and use of health services for women and their families while strengthening local health systems and increasing consumer input into theses systems of local care. RHSI and Loving Steps both target African-American women who are at a greater risk of experiencing infant death.[167]

Loving Steps currently funds services in three communities in Virginia. The program successfully serves 500 families per year. Discovering contributing causes of infant mortality is a key component of improving perinatal healthcare systems. Loving Steps supports a fetal and infant mortality review (FIMR) and local consortium in each of its three communities. The FIMR promotes community mobilization for healthier babies by identifying specific preventable factors that contribute significantly to perinatal morbidity and mortality by recommending changes in health and human service programs. The FIMR includes case selection, a home interview with the mother who has experienced a loss, medical record abstraction, case review by professionals, community response, and evaluation. [168]

The following table shows the IMR of National Healthy Start participants during its first three years of operation. While the IMR of this population is greater than the national average, it has declined considerably since 2004. The Virginia programs are not included in the 1991 – 1993 rates but are showing the same promising decline.

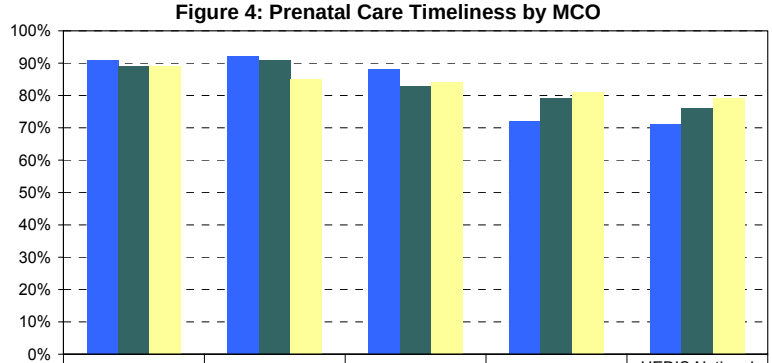
Table 1: Comparison of U. S. and Healthy Start Birth Outcomes[169]

Rate per 1,000 live births	U.S. 1991	U.S. 2004	National Healthy Start 1991-1993	National Healthy Start 2004	Loving Steps Program 2004
Infant Mortality Rate	8.9	6.78	13.0-28.7	7.65	0
Low Birth Weight Rate	7.1	7.8	17.3-23.8	9.3	7.8

Source: Virginia Department of Health, Office of Family Health Services

BabyCare is another statewide initiative that aims to reduce infant mortality. This program was created in 1988 and is available to Medicaid eligible, high-risk pregnant women and children. The home visiting team is comprised of registered nurses or social workers. The team conducts full assessments of the expectant mother and her surroundings to develop a service plan to minimize the determined risks. Two types of services, Expanded Prenatal Services and Maternal and Infant Care Coordination (MICC), are provided by the BabyCare program. One of the more active BabyCare programs is the Chesapeake Health District. The annual IMR for program participants in the Chesapeake district is zero, compared to the overall rate of 10.4 deaths per 1,000 live births for the district.[170]

Figure 4: Prenatal Care Timeliness by MCO



	Anthem	CareNet	Optima	VA Premier	HEDIS National Medicaid Average
2004	91%	92%	88%	72%	71%
2005	89%	91%	83%	79%	76%
2006	89%	85%	84%	81%	79%

Source: NCQA HEDIS Data Submission Tool 2004-2006

The Department of Medical Assistance Services (DMAS) Medicaid MCOs all offer prenatal care services as part of disease management programs. The goal for these programs is early access to prenatal

[167] Virginia Department of Health, Office of Family Health Services.

[168] Virginia Department of Health, Office of Family Health Services.

[169] Virginia Department of Health, Office of Family Health Services.

[170] Department Of Medical Assistance Services.

care and supportive services. Figure 4 displays positive results indicating that members of these plans are receiving prenatal care in a timely and efficient manner.

The programs highlighted in this section are representative of the many prevention and awareness organizations Virginia has to offer to address the issue of Virginia's IMR. Attached is an inventory of initiatives and programs, including their purpose, eligibility, source of revenue, and target locality and population addressing infant mortality in Virginia (Appendix K).

WHY PURSUE POLICY CHANGE?

Approximately 300 infants are born each day in Virginia. Many of these babies die due to factors associated with prematurity. The average cost covered by taxpayer dollars for a baby carried to term is $3200. However, for a premature baby who remains in the Neonatal Intensive Care Unit (NICU) for an average of eleven days, the cost varies from $31,000 to $48,000. This astronomical cost only addresses the problems associated with premature babies while they are in the NICU. Some of these babies will have life threatening birth defects requiring surgeries, other costly advanced medical treatments, and lifelong expensive care. It is apparent that there are significant financial incentives in promoting awareness and addressing the factors that contribute to Virginia's IMR. [171]

Infant death and morbidity is a phenomenon that can often be prevented. The loss of a baby can contribute to a sense of stress, depression, and hopelessness. Infant mortality indirectly reflects the general status of the healthcare system for women and infants; therefore, any efforts to prevent infant mortality will also improve the birth outcomes for all infants.[172] The citizens of Virginia have a vested interest in reducing the IMR to ensure improved health status for women and infants, economic productivity, and the future success of the Commonwealth.

RECOMMENDATIONS

The Quality, Transparency, and Prevention Workgroup (QTP Workgroup) of the Health Reform Commission (Commission) developed several recommendations to reduce infant mortality in the Commonwealth. Both the QTP Workgroup and Commission had to narrow the number of recommendations to those that were felt to be of most importance. For a listing of all of the recommendations that were evaluated, please see Appendices L.

Recommendations for infant mortality

A. In 1999, and again in 2003, the Virginia Department of Health's (VDH) Division of Women's and Infants' Health (DWIH) in the Office of Family Health Services, prepared a report on perinatal underserved areas in the Commonwealth of Virginia in collaboration with the Regional Perinatal Councils. DWIH defined perinatal underserved areas as localities in need of prenatal healthcare services resulting from manpower and resource deficiencies, and where these services are underutilized.

   Establishing the authority of the Board of Health to develop criteria and promulgate regulations for Perinatal Underserved Areas would encourage community planning and enhancement of healthcare delivery systems for pregnant women and their infants. In addition, it would assist public and private organizations in perinatal policy development and resource allocation. Designating and defining perinatal underserved areas would provide an accurate baseline and establish benchmarks for monitoring and reporting for the state health department, local health departments, Regional Perinatal Councils, and private organizations interested in improving the health status of women and infants. In addition to

[171] Virginia Department of Health, Office of Family Health Services.

[172] Virginia Department of Health, Office of Family Health Services.

customary epidemiological data, the determination of perinatal underserved areas would include geographical analysis of the distance traveled for perinatal and birthing services and an analysis of the geographic clustering and dispersions of undesirable perinatal outcomes, such as fetal mortality, neonatal and infant mortality rates, at the local neighborhood level. This will assure that major factors known to differentially affect access to obstetrical care and birth outcomes in rural and urban areas are taken into account.

Central to the development of the Perinatal Underserved Area designation is the need to define "targeted high priority intervention areas" for local health districts and provide an understanding of the existing racial, ethnic and socio-economic disparities that currently exist. The Perinatal Underserved Area would be developed to provide context, and circumscribe what has until now been a diffuse concern for infant mortality and other infant morbidities. The major caveat when defining perinatal underserved areas is they must be updated periodically in a timely fashion in order to function as a viable health-planning tool. The definition of these areas must be reviewed on a periodic basis by the Board of Health and the adequacy of the designation process must be reassessed. Placing the responsibility to define the Perinatal Underserved Areas with the Board of Health, should render the process less cumbersome and more responsive to new data and data analysis techniques.

- *The Governor should provide the Board of Health with the authority in the Code of Virginia to develop criteria to identify and establish perinatal underserved areas.*

B. The American College of Obstetricians and Gynecologists (ACOG) recommends their members use a 12-page universal record that includes screening for infections, genetic disorders, domestic violence, sexual assault, depression, and alcohol and drug use in the antenatal period. VDH publishes a manual that outlines the expected risk factors to be assessed on every patient. These guidelines are based upon a combination of the ACOG guidelines and state regulations and law.

Specific programs in the state such as Healthy Start, CHIP of Virginia, and Healthy Families use a risk-screening tool to determine eligibility for their programs. Currently, Virginia Medicaid reimburses for the completion of a risk-screening tool to determine pregnant women's eligibility for its high-risk case management services, BabyCare. The Medicaid managed care organizations also have similar screening processes. Recently, DMAS and VDH staff have been exploring the use of a screening tool for all pregnant women covered by Medicaid to not only be used in BabyCare but also in the VDH Resource Mothers and Healthy Start programs. This screening tool would assess for all medical factors including chronic illnesses that increase the risk of infant mortality and risky behaviors such as use of illicit drugs, alcohol, or tobacco, depression, and domestic violence. The screening tool would enable interventions and the promotion of healthy lifestyles during pregnancy in order to improve birth outcomes.

- *The Governor through the VDH and DMAS should promote one screening tool for pregnant women for all publicly funded programs and should make training available to all providers.*

C. Home visiting has been an integral strategy of public health nursing, social work, and community development for the past century. Home visiting is based on the concept that parents are the key to prevention and health promotion. Home visiting programs were developed at the federal and state levels to address prevention of child abuse and neglect, early intervention for the developmentally delayed infant and toddler, targeted case management of high-risk pregnancies, community-based intervention for substance-abusing women and increased access to healthcare. Home visiting is a strategy for offering information, guidance, and support to families in the place in which they are typically most comfortable: their own homes.

National research has identified key elements in home visiting programs that lead to successful outcomes; however, these elements have not been standardized, used to evaluate, or used as criteria for funding programs in Virginia. In the Commonwealth, there are at least 10 major public and private agency-sponsored home visiting programs serving pregnant women, infants, children, and their families. Four of these programs were explicitly designed to reduce infant mortality and morbidity through intervention during the prenatal period: BabyCare, the Medicaid managed care contracts, the Resource Mothers Program, and the Healthy Start/Loving Steps.

- *The Governor should provide additional funding to effective public and private prenatal home visiting programs that meet those criteria established for publicly funded home visiting.*

D. There is renewed interest in encouraging women to become healthier prior to and between pregnancies. This is fueled by the increase in the number of women who enter pregnancy with a chronic condition(s) and the increase in the average age of women giving birth. Although multiple programs are currently in place to directly or indirectly decrease infant mortality, gaps exist in services related to management of conditions that negatively impact birth outcomes such as obesity, glucose abnormalities, cardiovascular disease, and hypertension. For example, WIC provides nutrition education services in each locality but does not provide medical nutrition therapy for diagnosed medical conditions that may impact future pregnancy outcomes.

There are multiple areas where interconception care could be improved. Obesity exacerbates many of these conditions that are negatively impacting pregnancy outcomes. Increasing VDH's ability to provide nutritional education is a viable option to proactively address conditions in this group of childbearing aged women. Providing nutrition intervention to women with a BMI value greater than 30 may decrease the number of women who enter pregnancy obese, ultimately decreasing the risk of developing complications in pregnancy.

- *The Governor should provide funding to develop, evaluate, and replicate intensive evidence-based interconception care and care coordination models for women at high social and medical risk*

E. Recently, there has been renewed interest on periodontal diesease and its potential effects on preterm birth, low birth weight, and infant mortality. While the exact effects are not known, it is believed that providing pregnant women with good oral healthcare is positive and could potentially affect the number of preterm births, low birth weight births, and infant mortality in the Commonwealth. The Medicaid and FAMIS programs in Virginia do not currently offer dental services to pregnant women. The Workgroup believe it is critical to offer this population access to dental services.

- *The Governor should provide funding to the DMAS to provide dental care to pregnant women in Medicaid and FAMIS.*

F. VDH has been working to promote safe sleeping and prevent SIDs through its Regional Perinatal Councils (RPCs), Resource Mothers Program (RMP), and the Loving Steps Program (Healthy Start). These programs have adopted the evidence-based "Back to Sleep" campaign developed by the American Academy of Pediatrics to promote safe sleep positioning. Training is provided to RMP home visitors and Loving Steps staff on how to instruct new parents in safe sleeping practices for their newborns. All RPCs use Title V funds for education on Back to Sleep/safe sleeping through doing presentations and distributing brochures to providers, social services staff, home visitors, hospitals, pediatric

offices, and community groups. Every year SIDs and safe sleeping are topics included in the perinatal outreach education programs in all RPCs.

Even though there has been significant attention to the prevention of SIDS, funding has been sporadic, short term, and very limited. Adequate, sustained funding and a coordinated effort are needed on a statewide basis to effectively communicate the importance of safe sleeping to all new parents with special attention to those populations at most risk. The RPCs are well-positioned to partner with local health departments and other community organizations to launch a coordinated campaign. This would require funding for additional personnel time, educational materials including videos, social marketing expenses, and travel funds for more presentations to provider and community groups.

- *The Governor should provide funding to educate parents and providers regarding SIDS and safe sleeping environments.*

ESTIMATED COSTS

Table 2: Pricing of Infant Mortality Recommendations (Annual Estimated Costs)

1A. Provide the Board of Health with the authority in the Code of Virginia to develop criteria to identify and establish perinatal underserved areas	$ 65,763
1B. Implement one screening tool for pregnant women for all publicly funded programs and make training available to all providers	$ 33,800
1C. Provide additional funding to effective public and private prenatal home visiting programs that meet those criteria established for publicly funded home visiting	$ 6,800,000
1D. Develop, evaluate, and replicate intensive evidence-based interconception care and care coordination models for women at high social and medical risk	$ 631,000
1E. Provide funding to the Department of Medical Assistance Services to provide dental care to pregnant women in Medicaid and FAMIS Moms*	$ 3,100,000
1F. Educate parents and providers regarding SIDS and safe sleep environment	$ 156,000
Total	**$ 10,786,563**

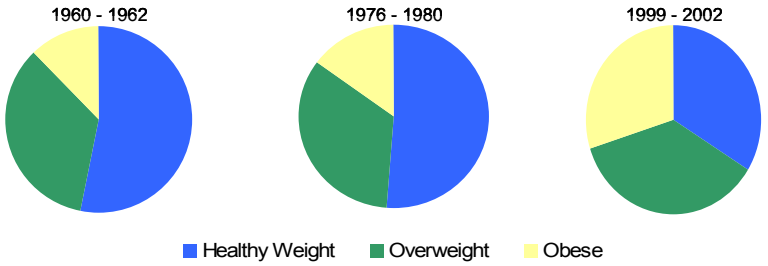
*This estimated cost is for women who would currently qualify for Medicaid or FAMIS Moms, i.e. those with incomes less than 185% FPL. Should the income levels be increased through the Access Workgroup's recommendations, this cost would also increase.

The National Effects of the Obesity Epidemic

Obesity is defined as an excess of adipose tissue. The Body Mass Index (BMI) is the most common measure of adiposity. A BMI ranging from 18.5 to 25 is regarded as 'ideal', a BMI ranging from 25 to 30 is overweight, and a BMI of 30 is considered the threshold for obesity. There are 35 chronic diseases associated with the obesity epidemic, each of which strains our nation's healthcare resources. Some of these diseases include heart disease, diabetes, high blood pressure, and cancer. The percentage of overweight and/or obese Americans is rapidly increasing. The spread of obesity has had a severe financial impact and is affecting the productivity of our nation.[173]

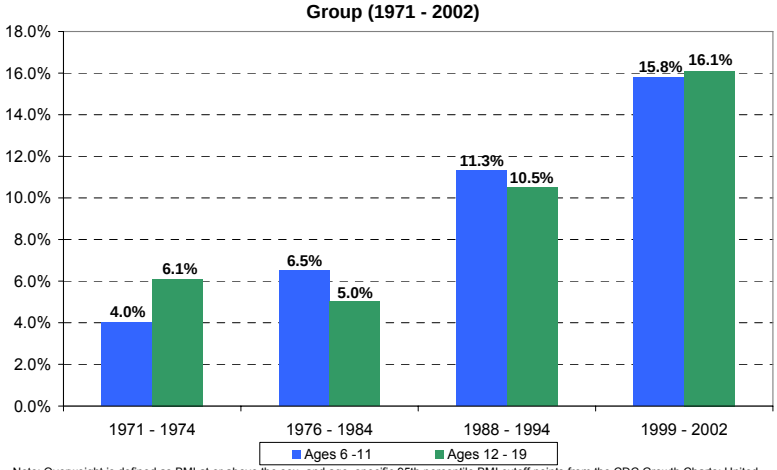
Over the past twenty-five years, adult obesity rates have risen nearly 10 percent. Today, more than two-thirds of the American adult population is overweight or obese. Reliable projections forecast that 73 percent of the adult population may be overweight or obese by 2008.[174] Since 1980, the rate of childhood obesity (up to age eleven) in America has more than doubled. Currently over nine million American children are overweight or obese and this number is projected to rise. The obesity rate among adolescents (age twelve to nineteen) has risen more rapidly than that of children. Obesity among adolescents has increased from 5 to 17 percent since 1980.[175]

Figure 1: Proportion of Individuals Ages 20 to 74, by Weight Status, 1960 – 2002



Note: Overweight is defined as having 25 ≤ BMI < 30; obese as BMI ≥ 30; healthy weight as 18.5 ≤ BMI < 25
Source: Centers for Disease Control and Prevention (2005)

Figure 2: Children and Adolescents Considered Overweight, by Age Group (1971 - 2002)



Note: Overweight is defined as BMI at or above the sex- and age- specific 95th percentile BMI cutoff points from the CDC Growth Charts: United States.
Source: Center for Disease Control and Prevention (2005)

[173] National Summit on Obesity Policy. *Facts about Obesity*. Retrieved June 14, 2007, from: http://www.campaigntoendobesity.org/ObesityFactSheet.pdf.

[174] National Summit on Obesity Policy. *Facts about Obesity*. Retrieved June 14, 2007, from: http://www.campaigntoendobesity.org/ObesityFactSheet.pdf.

[175] National Summit on Obesity Policy. *Facts about Obesity*. Retrieved June 14, 2007, from: http://www.campaigntoendobesity.org/ObesityFactSheet.pdf.

Environmental and Cultural Forces Driving Obesity Rates

Federal legislation governs U.S. food and agricultural policy. According to some experts, the fundamental problems with overproduction and agricultural policy must be confronted before any public health policies addressing obesity will be effective. Until recently, agricultural policies and practices have been disconnected from the health needs of Americans. However, health and environmental professionals have begun working together to support agriculture as a means that can enhance public health.[176]

Now more than ever, unhealthy foods are extremely inexpensive and accessible. Foods that tend to be high in calories, sugar, and fat, including fast food and prepackaged foods are widely available. A study in 2002 concluded that portion sizes, particularly for packaged foods, beverages, and foods of minimal nutritional value, began to increase during the 1970s and rose rapidly during the 1980s. Today, changes in portion sizes have continued to mirror the increasing body weights of Americans. Another study indicated that small grocery stores (which are less likely to carry produce and other healthy items) are four times more likely to appear in low-income neighborhoods than in the wealthiest neighborhoods. However, there are only half as many supermarkets (which contain a wider variety of healthy foods and fresh produce) in poorer areas. There tends to be fewer fruit and vegetable markets in poorer and non-white areas. Due to these circumstances, residents often rely on what is readily available, such as fast food outlets and the less healthy, less expensive options offered at corner stores.[177]

Americans are much less active today than in previous generations. Over 50 percent of U.S. adults do not participate in sufficient physical activity to provide health benefits, and nearly one quarter of adults are completely inactive during their leisure time. Walking as a form of travel has decreased by 40 percent between 1977 and 1995 for both children and adults. However, trips made in an automobile increased to 90 percent of all total trips. The increasing dependence on automobiles is also influenced by community design, inadequate transit, and greater car ownership.[178]

Obesity and its Effects on Virginia

In 2003, Virginia participated in its first state-level, obesity-related healthcare study. According to the Research Triangle Institute International and the Centers for Disease Control and Prevention (CDC), Virginia's estimated direct obesity-attributable healthcare costs were greater than $1.6 billion in 2003. This accounted for 5.7 percent of the adult medical expenditures. In 2005, 25 percent of adults in Virginia were obese, while 36 percent were overweight.[179] As the number of overweight and obese Virginians continues to rise, projections indicate that a greater percentage of healthcare costs will be required to treat this population. In a 2006 study conducted by researchers at the University of Baltimore to evaluate what states are doing to treat obesity as a threat to public health, Virginia received a C for its effort to control obesity and its efforts to combat childhood obesity.[180]

It is believed that today's youth could potentially be the first generation who will not outlive their parents due to an increase in the prevalence of childhood obesity-linked chronic diseases. The children of today could end up living two to five years less than they otherwise would, due to obesity.[181] Many studies indicate a correlation between obesity and depression, but it is usually unclear which is the cause and

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[176] Grantmakers in Health. (February 2007). *"Reversing the Obesity Epidemic: Policy Strategies for Health Funders."* Retrieved June 14, 2007, from: http://www.gih.org/usr_doc/Reversing_the_Obesity_Epidemic_no_28.pdf.

[177] Grantmakers in Health. (February 2007). "Reversing the Obesity Epidemic: Policy Strategies for Health Funders." Retrieved June 14, 2007, from: http://www.gih.org/usr_doc/Reversing_the_Obesity_Epidemic_no_28.pdf.

[178] Grantmakers in Health. (February 2007). "Reversing the Obesity Epidemic: Policy Strategies for Health Funders." Retrieved June 14, 2007, from: http://www.gih.org/usr_doc/Reversing_the_Obesity_Epidemic_no_28.pdf.

[179] Virginia Department of Health. *Virginia's Obesity Epidemic*. Retrieved June 14, 2007, from: http://www.vahealth.org/wic/champion/Virginiaspecficobesitydata.pdf.

[180] University of Baltimore. *The UB Obesity Report Card*. Retrieved August 3, 2007, from: http://www.ubalt.edu/experts/obesity/.

[181] Olshanky, S. J. (2005). A Potential Decline in Life Expectancy in the United States in the 21st Century." *The New England Journal of Medicine* 352, no. 11, p. 1138-45.

which is the effect.[182] According to Goodman and Whitaker, "adolescent obesity is a strong predictor of adult obesity, and adult obesity has been associated with depression, especially in women. Studies have also suggested an association between depression in adolescence and a higher body mass index in adults."[183]

Virginia Schools and Childhood Obesity

The National Association for Sport and Physical Education recommends that elementary schools provide 150 minutes and middle and high schools provide 225 minutes each week of instructional physical education. To achieve optimal results, the teacher to student ratio in physical education classes should not exceed 1:25 in elementary schools or 1:30 in middle and high schools. The Virginia Board of Education is currently considering amendments to the Standards of Accreditation that would require elementary and middle schools to implement physical fitness policies in the Physical Education Standards of Learning.[184]

In 2005, Longwood University created a course for elementary teachers on teaching health and physical education. They generated a survey to evaluate the current health and physical education practices in Virginia schools. There were 109 school divisions that responded, representing over 1,000 primary and elementary schools throughout the Commonwealth. Based on the data collected, 28 percent of the schools provide physical education two days per week and 22 percent of the schools provide physical education one day each week. In a majority of school districts, 53 percent, physical education classes meet for thirty minutes. In elementary schools, 91 percent of children have recess each day varying between fifteen and twenty minutes. This allows for, but does not require, students to be physically active daily. When factoring in the average weekly physical education and recess for the responding schools, it is apparent that Virginia schools fall short of meeting the proposed recommendation in days per week and minutes for physical education and recess.[185]

Virginia has studied North Carolina's *Eat Smart*: *North Carolina's Recommended Standards for All Foods Available in School.* This program is geared towards removing the sale of foods of minimal nutritional value (FMNV) for students and providing a well rounded, balanced menu that targets each of the four food groups. Currently under Virginia regulations, the sales of FMNV are prohibited in schools from 6am until the end of breakfast and from the beginning of the first lunch period until the conclusion of the final lunch period. Like North Carolina, Virginia is one of only 23 states whose laws are more restrictive than the US Department of Agriculture's (USDA) requirements in governing the sale of competitive foods (foods and beverages that 'compete' with the meals provided by school breakfast and lunch programs). However, the USDA's regulations pertaining to the sale of competitive foods has not been updated since 1979 and are currently considered to be relatively lenient and outdated. Virginia would likely experience a favorable change if similar regulations were enacted to further restrict the availability of competitive foods in schools, such as those that currently exist in West Virginia, Kentucky, Maryland, North Carolina, and New Jersey.

WHY PURSUE POLICY CHANGE

The obesity-linked health costs in Virginia currently exceed $1.6 billion annually. If Virginia implemented public policy interventions to combat obesity, the state would garner multiple benefits. The loss of productivity in the workplace would significantly decline. Currently, the mean annual work days lost for an

[182] Lawson, W. (June 11, 2007) *The Obesity-Depression Link.* Retrieved June 21, 2007, from: http://psychologytoday.com/articles/pto-20030527-000010.html.

[183] Goodman, E and Whitaker, R.C. (September 2002). A Prospective Study of the Role of Depression in the Development and Persistence of Adolescent Obesity. *Pediatrics 110 (3),* p. 497-504.

[184] The National Association for Sport and Physical Education. *Is it Physical Education or Physical Activity?* Retrieved June 16, 2007, from: http://www.naspeinfo.org.

[185] National Association for Sport and Physical Education. (2006). *Recess for Elementary School Students (position paper)* Reston, VA.

individual of a healthy weight is 5.18 and 5.5 for men and women, respectively. The mean annual work days lost for an overweight individual is 5.35 and 6.22 for men and women, respectively, and 5.85 and 8.82 days per year for obese men and women, respectively.[186]

If the government were to intervene and actively work to reduce the obesity epidemic, the costs of obesity borne by society, particularly through Medicare and Medicaid, would significantly decrease.[187] In Virginia, Medicare obesity-linked expenses have reached $320 million annually, while Medicaid obesity-linked expenditures are approaching $374 million each year. The Medicare and Medicaid obesity-attributable costs are solely based on direct medical costs, such as preventive, diagnostic, and treatment services, and do not account for indirect costs to the Commonwealth, which include decreased productivity and absenteeism.[188]

The financial costs associated with obesity are comparable to other chronic diseases. According to 2003 data, the direct obesity-linked cost to taxpayers in the United States was $75 billion. These astronomical numbers should provide a financial incentive for Americans to control the spread of obesity. Because 35 chronic diseases are associated with obesity, it is apparent that as obesity declines, not only will the direct costs borne to society be reduced, but the costs of other related diseases will as well. If the prevalence of obesity, particularly in youth, declines over time the amount spent to treat diseases, such as type two diabetes and coronary heart disease will begin diminish. The following chart exhibits the financial impact that several of the leading chronic diseases have on the United States.

Table 1: Direct Cost of Chronic Care in the US (2003, Billions) [189]

Disease	Direct Cost
Obesity	$75.0
Type II Diabetes	$73.7
Coronary Heart Disease	$52.4
Hypertension	$28.2
Arthritis	$23.9
Breast Cancer	$7.1

Traditional approaches to the problem of increasing obesity rates have focused on behavioral alterations rather than addressing the origin of these choices. Reversing the obesity epidemic requires more than merely encouraging individuals to eat less and exercise more. Changes to health policies that deal with the environmental aspects altering dietary habits and physical activity patterns can make efforts to modify behavioral changes more successful. According to *Reversing the Obesity Epidemic: Policy Strategies For Health Funders,* "Our nation's experience with food and activity guidelines underscores the limits of informational campaigns divorced from environmental changes. Since the 1950s, federal agencies and private health organizations have issued over 37 versions of guidelines advising Americans to reduce energy intake, raise energy expenditure, or both. Rarely did these guidelines address environmental or social factors, and based on the continuing rise in obesity rates, these guidelines are notable for their ineffectiveness (4)."[190]

[186] Wolf, A. Department of Health Evaluation Sciences, University of Virginia School of Medicine. *Trimming the Fat: The Economic Burden of Obesity & Cost Benefit of Treatment*.

[187] Grantmakers in Health. (February 2007). "Reversing the Obesity Epidemic: Policy Strategies for Health Funders." Retrieved June 14, 2007, from: http://www.gih.org/usr_doc/Reversing_the_Obesity_Epidemic_no_28.pdf.

[188] Centers for Disease Control and Prevention. (May 22, 2007). *Overweight and Obesity*. Retrieved July 6, 2007, from: http://www.cdc.gov/nccdphp/dnpa/obesity/economic_consequences.htm.

[189] Wolf, A. Department of Health Evaluation Sciences, University of Virginia School of Medicine. *Trimming the Fat: The Economic Burden of Obesity & Cost Benefit of Treatment*.

[190] Grantmakers in Health. (February 2007). "Reversing the Obesity Epidemic: Policy Strategies for Health Funders." Retrieved June 14, 2007, from: http://www.gih.org/usr_doc/Reversing_the_Obesity_Epidemic_no_28.pdf.

Policy strategies have been shown to be an effective tool to combat obesity. The obesity epidemic is a result of both considerable changes in our culture and in the environment in which physical activity and dietary choices are made. Public policy can create behavioral norms and shape the environment in which personal choices are made and provide a mechanism for reaching large numbers of people.[191]

RECOMMENDATIONS

The Quality, Transparency, and Prevention Workgroup (QTP Workgroup) of the Health Reform Commission (Commission) developed several recommendations concerning obesity in the Commonwealth. Both the QTP Workgroup and Commission had to narrow the number of recommendations to those that were felt to be of most importance. These recommendations can be broken down into what should be done for the children, state employees, and the community. For a listing of all of the recommendations that were evaluated, please see Appendices M.

Recommendations to combat childhood obesity

A. In an effort to address healthy lifestyle issues among Virginia schoolchildren, the Governor's Nutrition and Physical Activity Scorecard was developed in 2005. The Scorecard, which is part of the *Healthy Virginians* initiative, is an incentive program intended to drive best practices and local policy change, enhance student health, and improve academic achievement. Schools are encouraged to use this tool for identifying best practices and measuring their progress towards meeting the nutrition and physical activity needs of students. The online Scorecard can be accessed at http://www.virginia.gov/doe/login.html.

Since the Scorecard's inception in 2005, 508 of the more than 1,800 public schools in Virginia or 28 percent have used the online Scorecard assessment tool. Of those, 32 or 1.7 percent, have earned award status (5 Gold, 13 Silver, and 14 Bronze) and 14 more are pending review. These numbers have increased considerably since the development of Local Wellness Policies by school divisions, as required for participation in the USDA's National School Lunch Program. Continuing to expand the Scorecard initiative is critical to achieving success with policy change at the school level. The continued recognition of schools that achieve award status encourages all schools to adopt high standards for physical activity and nutrition.

- *The Governor should develop additional incentives to increase school participation in the Governor's Nutrition and Physical Activity Scorecard program including, but not limited to:*

  a. *Raising visibility and recognition through partnerships in the community;*
  b. *Sending a letter from the Governor to school principals to encourage participation and to commend those who receive awards;*
  c. *Continuing to evaluate, strengthen, and improve the scorecard, i.e. developing a school system/division award, etc; and*
  d. *Recognizing schools and school systems through visits by the Governor, Secretary of Health and Human Resources, and/or Secretary of Education.*

- *The Governor should encourage public schools to follow the Institute of Medicine (IOM) report, Nutrition Standards for Foods in Schools: Leading the Way Toward Healthier Youth, for administering the sale of "competitive foods" in public schools.*

[191] Grantmakers in Health. (February 2007). "Reversing the Obesity Epidemic: Policy Strategies for Health Funders." Retrieved June 14, 2007, from: http://www.gih.org/usr_doc/Reversing_the_Obesity_Epidemic_no_28.pdf.

B. The Washington Post Article, "Update: When It Comes to a Balanced Lunch, Arlington Schools Say Spuds Don't Suffice," notes that the school divisions in Arlington, Alexandria, Falls Church, and Faquier County have joined forces to buy more nutritious food at bulk prices. This model should be expanded and supported at the state level so that all school divisions would have access to bulk prices for healthy foods. This type of model could be used to increase farm to school initiatives.

By leveraging its buying power, the state would be helping schools and children have access to the right foods. The state could charge each school division a small fee to have access to the bulk prices, thereby enabling the program to pay for itself. This type of program could be expanded to all state agencies. This would produce even greater buying power and could lower the fees necessary to be a part of the program.

- *The Governor should create a bulk purchasing model for healthy foods initially targeting school divisions with the intent to expand to all state agencies.*

C. To implement the physical fitness strand of the Physical Education Standards of Learning, the Department of Education (DOE) has developed the Virginia Wellness Related Fitness Test (VWRFT). The VWRFT is designed to evaluate and provide baseline wellness-related fitness data for Virginia's students. Analyzing VWRFT results over time provides a quantitative indicator of general physical fitness levels of male and female students at both the individual school and local school division levels. The six major components of the test are aerobic capacity, upper body strength, abdominal strength, flexibility, trunk extensor, and body composition (i.e., body mass index). Administration of the test is optional for Virginia public schools, but almost all public schools in the Commonwealth administer the test. However, not all of those schools collect body mass index data as the body composition component of the VWRFT is optional. In addition, not all schools report their VWRFT data to DOE.

A quality health and physical education program seeks to develop affective cognitive and behavioral components for all students, regardless of gender, age, disability, or any other factor. Regular physical activity contributes to good health, function, learning, and well-being, and is important throughout a person's lifetime. Therefore, school programs should have the long-term view of promoting appropriate physical activity rather than focusing only on developing "athletic" physical fitness. The VWRFT emphasizes maintaining an acceptable level of physical fitness.

- *The Governor, should establish state performance benchmarks or goals for physical fitness and BMI through the VA Wellness Related Fitness Test (VWRF). This would include:*
  a. *Requiring the reporting of this data by all school divisions to DOE;*
  b. *Developing benchmarks for the Commonwealth based on the aggregated data; and*
  c. *Using a data management system to create individualized report cards for parents to see their child's fitness levels.*

D. The USDA school meal programs are required to offer fruits, vegetables, whole grains, low-fat milk, low-fat meat and meat alternate items every day. In the Commonwealth, the lunch and breakfast programs are the only place in school where nutrition standards are required. School nutrition programs are expected to be financially self-supporting; however, this has become more and more difficult as costs and expectations continue to increase. In order to maintain school meals as a low cost, nutritionally sound tool in the fight against childhood obesity, additional state funding is important.

School nutrition programs facing the financial pressure of meeting escalating food costs, as well as increased salary and benefit costs for employees, have been forced to seek

opportunities to increase revenue. These have included the sale of less nutritious a la carte foods and beverages. Virginia has never provided more than the federally required minimum amount of state funding for school lunches. This fixed amount of $5.8 million has been in place since 1980. In 1995 the average reimbursement was more than 6 cents per meal. This has declined to just 4.77 cents per meal in 2006. Increases in student participation further decrease the amount of state reimbursement per meal because the amount is fixed. Increasing state funding would allow school nutrition programs to offset the additional costs of nutritious menu choices.

Per meal funding for the school breakfast program has never been implemented in Virginia. Since 2005, a state funding incentive has been provided for new meals served. This incentive has generated a nearly 16 percent increase in breakfasts served in just two years. A per meal funding incentive would provide support to those school divisions that had previously established high levels of student participation by providing financial support for all meals served, not just for new meals. Additionally, per meal funding would provide financial support for the increased use of higher cost, nutritious items such as fresh fruit, yogurt, and whole grain breads at breakfast.

In the prior fiscal year (FY) (October 2005 – September 2006), the federal government provided Virginia with $37,551,338 for the school breakfast and $135,918,007 for the school lunch programs. The federal government sets standard rates per meal. In FY2006 – 2007, schools were reimbursed by the federal government $1.31 for free breakfast, $1.01 for reduced breakfast, and $0.24 for full price breakfast. The state reimbursed schools with a $0.20 incentive during this same time period. In FY2006 – 2007, schools were reimbursed by the federal government $2.40 for free lunch, $2.00 for reduced lunch, and $0.23 for full price lunch. During this same time, the state reimbursed schools $0.0472 per lunch served. Finally, during school year 2005 – 2006, Virginia schools served 33,083,834 breakfasts, a 6.85 percent increase over the previous school year, and 121,411,234 lunches, a 2.72 percent increase over the previous school year.[192]

While the Commonwealth receives significant federal funding for the school breakfast and lunch programs, this funding is primarily going to schools who have a high proportion of students who are on free or reduced breakfast and lunch. Therefore, for those school divisions in more affluent areas there are few incentives to offer healthy food because they receive few federal funds and few state funds to help cover the costs of their programs. By providing additional state funding for both the school breakfast and school lunch programs, incentives are being put in place to offer more healthy options. In addition, with additional state funding, the state can put certain requirements in place such as, following the American Dietary Guidelines, vending machines being turned off during breakfast and lunch periods, etc. in order for the school division to be able to receive funding.

- *The Governor should increase funding for the school breakfast and school lunch programs to encourage greater participation and increase nutritional value and nutritious food options.*

E. Nutrition education is essential in the fight against childhood obesity. Children must understand the principles of good nutrition and be able to apply them in their daily lives in order to achieve and maintain optimal health. The knowledge of the nutrition professionals at the VDH is essential to the development of nutrition education tools that can be implemented by educators in public schools. Prepared lesson plans and instructional tools will allow educators to implement nutrition education through a variety of instructional methods.

[192] Department of Education, School Nutrition Programs.

The classroom teacher will be more likely to follow guidelines when curriculum and materials are readily available. In addition, the VDH is uniquely qualified to assure that the most current and scientifically valid information in included in these materials. The Health Smart VA Web site and VA Action for Healthy Kids initiatives, www.healthsmartva.org was developed as a collaborative effort between the DOE and the VDH to provide materials, websites, lesson plans for use by health and PE teachers.

- *The Governor should encourage partnering between the VDH and the DOE to develop lesson plans and instructional tools for nutrition and physical education based upon the health education SOL. The tools developed should increase focus, direction, and priority of health education for all schools.*

F. The CDC's coordinated school health program is a model that consists of eight interactive components: health education, physical education, health services, nutrition services, counseling, psychological, and social services, healthy school environment, health promotion for staff, and family/community involvement. While it is not expected or realistic to believe that the schools can solve the obesity epidemic in youth, schools do provide a facility in which many agencies can work together to improve the health status of youth. Currently, Virginia is not a part of the coordinated school health program. Twenty-three states currently participate in the coordinated school health program, including all of Virginia's neighboring states, with the exception of Maryland. The CDC provides competitive grant funding to states to implement the Coordinated School Health Program. The next five year grant funding period will commence in March 2008. The CDC expects to issue the grant funding guidance to states within the next month.

The Youth Risk Behavioral Survey (YRBS) would allow Virginia to monitor priority health risk behaviors that contribute markedly to the leading causes of social problems, morbidity, and mortality among youth and adults. These behaviors, often established during childhood and early adolescence, include unhealthy dietary behaviors and inadequate physical activity, in addition to tobacco use, alcohol and other drug use, sexual behaviors (contributing to unintended pregnancy and sexually transmitted diseases), and behaviors that contribute to unintentional injuries and violence.

Statewide and locally representative YRBS data would support core public health functions of surveillance, data-driven program planning, and evaluation of program effectiveness. Analysis of the YRBS data would determine the prevalence of health risk behaviors, assess trends of such behaviors over time, and examine the co-occurrence of health risk behaviors. According to CDC's records in 2005, Virginia was only one of two states that did not utilize the YRBS in some fashion. The only other state was Louisiana, who did not participate due to Hurricane Katrina. It should be noted that some states have found particular questions to be controversial; therefore, the CDC permits the removal of questions and only using portions of the survey. The survey would provide the ability to compare results within Virginia and between Virginia and other states, as well as nationally. Specifically, implementation would allow Virginia to obtain reliable statewide and local data on youth behaviors related to obesity prevention, target interventions to the highest risk areas, and monitor outcomes of those interventions.

- *The Governor should recommend that the DOE apply for grant funding from the CDC in order to implement CDC's coordinated school health programs and Youthl Risk Survey..*

Recommendations for the community

A. In 2005, VDH began its Commonwealth's Healthy Approach and Mobilization Plan for Inactivity, Obesity and Nutrition (CHAMPION) initiative. This initiative was designed to help diverse stakeholders equip Virginia's communities with the tools they need to reduce

obesity rates. During 2005, approximately 700 people participated in nine separate focus group/planning meetings, in which they provided feedback on community strategies and ideas for increasing physical activity and improving nutritional habits. From these focus groups, four common themes for solutions evolved: media intervention, nutrition education, community involvement, and public policy. VDH staff has since been evaluating existing programs and interventions that address these four themes and that have demonstrated positive outcomes proven to be cost effective and replicable.

A statewide comprehensive obesity prevention plan is necessary to reduce the risks associated with the increasing epidemic of obesity. The CHAMPION plan will be unique in that it will have specific programs and projects addressing the contributing factors and themes identified by the focus groups. All programs and projects included will have been identified to be evidence-based, fully evaluated, successful, relatively inexpensive and relatively easy to implement.

- *The Governor should implement and fund the CHAMPION program to include:*
  a. *Establishing the Governor's statewide CHAMPION advisory committee;*
  b. *Identifying proven, evidence-based, cost effective programs that can be replicated in communities across the Commonwealth;*
  c. *Providing training, technical support, and seed money to community groups implementing programs contained in the statewide plan;*
  d. *Establishing and funding a primary care collaborative to improve the medical care and outcomes for youth who are at risk for overweight and those who are already overweight*

Recommendations for state employees

A. Access to healthy foods is essential in the fight against obesity. The state should ensure that both its employees and all of the people it serves have access to healthy foods. The Governor should issue an executive order (EO) requiring all state agencies, over a period of time, to increase the percentage of healthy foods offered in all state agency cafeterias, public school cafeterias, public higher education institutions, mental health facilities, correctional facilities, juvenile justice facilities, etc. The EO would be applicable to vending machines as well. The American Dietary Guidelines would be the basis for determining whether a food is considered healthy or not.

- *The Governor should issue an executive order directing all state agency cafeterias, public school cafeterias, public higher education institutions, mental health facilities, correctional facilities, juvenile justice facilities, etc. to improve nutritional offerings by following the American Dietary Guidelines.*

ESTIMATED COSTS

Table 2: Pricing of Obesity Recommendations (Annual Estimated Costs)

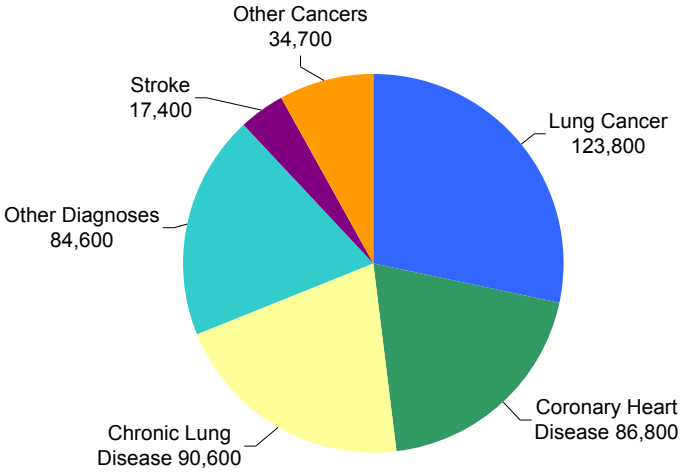
1A. Develop additional incentives and support mechanisms to increase school participation in the Governor's Nutrition and Physical Activity Scorecard program Encourage public schools to follow the IOM guidelines for administering the sale of "competitive foods" in public schools	Covered through CHAMPION	
1B. Create a bulk purchasing model for healthy foods initially targeting school divisions with the intent to expand to all state agencies	$	0
1C. Establish state performance benchmarks/goals for physical fitness and BMI through the VA Wellness Related Fitness Test (VWRF)	$	50,000

1D. Increase funding for the school breakfast and school lunch programs to encourage greater participation and increase nutritional value and nutritious food options	$	8,005,000
1E. Encourage VDH and DOE to partner to develop lesson plans and instructional tools for nutrition and physical education based upon the health education SOL	$	104,000
1F. Implement CDC's coordinated school health programs and Youth Behavioral Risk Survey to receive additional federal funding	$	0
2A. Fund the CHAMPION program	$	676,824
3A. Improve nutritional offerings in all state agency cafeterias, public school cafeterias, public higher education institutions, mental health facilities, correctional facilities, juvenile justice facilities, etc. to follow the American Dietary Guidelines		TBD
Total	**$**	**8,835,824**

The National Effects of Tobacco Use

In 2004, more than one in five Americans smoked, including 21 percent of adults and over 22 percent of high school students. Tobacco use, particularly smoking, harms nearly every organ in the human body, reducing the overall health and quality of life of smokers. Consequently, the primary cause of premature death in America is from smoking. It is estimated that 438,000 Americans die annually due to smoking. Each year smoking kills more Americans than AIDS, alcohol, car accidents, illegal drugs, homicides, and suicides combined. Approximately 38,000 additional Americans die each year from other forms of tobacco use, including chewing tobacco, or exposure to secondhand smoke. Tobacco-related deaths account for nearly one of every five American deaths each year.[193] There are currently 8.6 million Americans who are suffering from smoking-related illnesses. Unless smoking rates decline over the next 50 years, the number of Americans who suffer from smoking-related illnesses will increase significantly. It is projected that of those 20 million children under the age of eighteen that currently smoke, 6 million will die prematurely from a smoking-related illness.[194]

Figure 1: Annual Deaths Attributable to Cigarette Smoking United States, 1997–2001



The monetary costs of tobacco use are as equally grave as the health implications. Total annual public and private healthcare expenditures for smoking-related illnesses are $96.7 billion. In 2004, the costs to the federal government from smoking-related Medicare expenditures totaled $27.4 billion and Medicaid expenditures were $30.9 billion. The federal government assumes $4.98 billion in costs to treat Americans who suffer from the negative effects of secondhand smoke. Also, loss in productivity attributed to tobacco use each year total $97.6 billion.[195]

Tobacco and its Effects on Virginia

Similar to the outcomes nationwide, tobacco use is the number one leading preventable cause of death in the Commonwealth, accounting for more than 9,000 deaths annually in Virginia. It is projected that 152,000 children in Virginia under the age of eighteen today will ultimately die prematurely from smoking. In addition, approximately 1,000 adults, children, and babies die each year in Virginia as a result of others' smoking, either from secondhand smoke or smoking during pregnancy. In addition to smoking-related fatalities, nearly 200,000 Virginians currently suffer from serious smoking-related diseases.[196]

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[193]Centers for Disease Control and Prevention. (May 21, 2007). *Smoking and Tobacco Use*. Retrieved July 9, 2007, from: http://www.cdc.gov/tobacco/data_statistics/state_data/data_highlights/2006/index.htm.

[194]Centers for Disease Control and Prevention. (May 21, 2007). *Smoking and Tobacco Use*. Retrieved July 12, 2007, from: http://www.cdc.gov/tobacco/data_statistics/tables/health/attrdths.htm.

[195] Campaign for Tobacco-Free Kids. (March 2006). Toll of Tobacco in the United States of America. Retrieved July 12, 2007, from: http://tobaccofreekids.org/research/factsheets/pdf/0072.pdf.

[196] Campaign for Tobacco-Free Kids. (March 2006). The Toll of Tobacco in VA. Retrieved July 12, 2007, from: http://tobaccofreekids.org/reports/settlements/toll.php?StateID=VA.

Virginia ranks 26th highest in the nation for the adult smoking rate where 20.6 percent of Virginian adults are smokers. Utah has the lowest smoking rate for adults, at 11.5 percent. Since Virginia's percentage of adult smokers is relatively high, it is apparent that the Commonwealth needs to focus its efforts to promote smoking cessation. Currently, 7.5 percent of pregnant Virginians are smokers, ranking it as the 7th lowest percentage of pregnant smokers. Washington, D.C. has the lowest rate of pregnant women who smoke at 3.9 percent.[197]

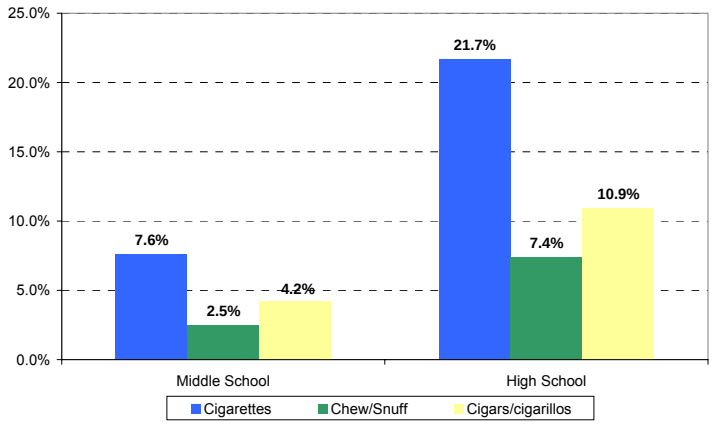
The Centers for Disease Control and Prevention (CDC) has recommended a minimum per capita amount each state should budget for tobacco control programs. During FY2006, Maine, Colorado, Delaware, and Mississippi were the only four states spending CDC's minimum recommended amount on tobacco prevention programs. The CDC recommended that Virginia dedicate $38.9 million for these programs; however, during FY2006 the Commonwealth allocated only $12.8 million, just 32.9 percent of CDCs recommendation. Virginia currently ranks 24th among states in funding for tobacco prevention programs.[198]

Teens and Tobacco: National and Virginia

The largest population of individuals that begin to smoke on a regular basis are teenagers under the age of eighteen. There are multiple factors associated with youth and tobacco use. Living environment largely influences the probability of teen smoking. Individuals who possess any or all of the following traits are much more likely to begin smoking at a young age: parents that smoke, approval of tobacco use by siblings or peers, lack of parental support or involvement, or possess a low socioeconomic status. Other personal factors that are connected with tobacco use in youth are low self-image or self-esteem, low levels of academic achievement, and believing in the functional benefits of tobacco use. Statistics also indicate that youth who smoke regularly are more likely to participate in higher risk sexual behavior and use alcohol or other drugs.[199]

Similar to the overall percentage of individuals who smoke and use tobacco, the number of teenagers involved in this behavior has also declined substantially nationwide over the past several decades. However, in recent years this decline has come to a halt, and some statistics indicate there has been a slight reversal with increased tobacco use. A 2005 survey reported that high school students in the U.S. who had smoked cigarettes over the past month increased from 21.9 percent in 2003 to 23 percent in 2005. In addition, 13.6 percent of high school students use smokeless tobacco. There may be an overlap between the two types of tobacco users. Approximately 800 million packs of cigarettes are sold to and consumed by teenagers each year in America.[200]

Figure 2: Virginia Youth Tobacco Use (2005)



Virginia has mirrored nationwide trends in youth smoking rates with an overall decline. However, in the past few years there has been a slight increase in the rate of smoking. This is particularly evident in the minority youth population. Hispanic youth at risk of becoming established smokers increased from 45

[197] Virginia Department of Health, Division of Chronic Disease Prevention and Control. Tobacco Use Control Project.

[198] Centers for Disease Control and Prevention. (May 22, 2007). *Smoking and Tobacco*. Retrieved July 12, 2007, from: http://www.cdc.gov/tobacco/tobacco_control_programs/stateandcommunity/index.htm#about.

[199] Centers for Disease Control and Prevention. (May 22, 2007). *Smoking & Tobacco Use*. Retrieved July 9, 2007, from: http://www.cdc.gov/tobacco/data_statistics/Factsheets/youth_tobacco.htm.

[200] Campaign for Tobacco-Free Kids. (March 2006). Toll of Tobacco in the United States of America. Retrieved July 12, 2007, from: http://tobaccofreekids.org/research/factsheets/pdf/0072.pdf.

percent in 2003 to 47 percent in 2005, and there were similar findings among African-American youth, with an increase from 37 percent in 2003 to 42 percent in 2005. During the same time frame the white youth population experienced a 3 percent decrease in the likelihood of becoming established smokers.[201]

Each year 9,700 children in Virginia under eighteen years of age become new daily smokers. In Virginia, 18 million packs of cigarettes are bought and smoked each year by the youth population. Individuals who begin smoking or using other forms of tobacco in their youth are significantly more likely to die prematurely from tobacco-related illnesses than individuals who begin this same abusive behavior at a later age.[202]

Effects of Secondhand Smoke

Smoking and other forms of tobacco use are a harmful lifestyle choice made by many Americans. These individuals often live shorter lives and suffer from many tobacco-related diseases. However, many individuals who choose not to smoke are also affected by the harmful ramifications of those who do smoke. "Secondhand smoke, also known as environmental tobacco smoke, is a complex mixture of gases and particles that includes smoke from the burning cigarette, cigar, or pipe tip (side stream smoke) and exhaled mainstream smoke. Secondhand smoke contains at least 250 chemicals known to be toxic, including more than 50 that can cause cancer."[203]

Most exposure to secondhand smoke occurs in American homes and workplaces. Nonsmokers who are exposed to such secondhand smoke increase their risk of developing heart disease by 25 to 30 percent and lung cancer by 20 to 30 percent. More than 125 million nonsmoking Americans are continuously exposed to the harmful effects of secondhand smoke.[204] There are many secondhand smoke related diseases and illnesses such as:

- Developmental effects – including spontaneous abortion, low birth weight infants, SIDS, and adverse impact on cognition and behavior;
- Respiratory infections – including exacerbation of cystic fibrosis, decrease pulmonary function, asthma, and adult eye and nasal irritation; and
- Carcinogenic effects – including cervical, breast, and nasal sinus cancer.[205]

In the United States, secondhand smoke exposure is responsible for 150,000 to 300,000 new cases of bronchitis and pneumonia each year in children under two years of age. Nearly 60 percent of children aged three to eleven in the United States are victims of secondhand smoke, primarily because of parents that smoke.[206]

Resources to Reduce Tobacco Use

Tobacco use takes a large toll on the quality of life of Virginians. There are multiple resources Virginia currently utilizes, but could continue to strengthen, in order to assist in lowering the prevalence of tobacco use in the Commonwealth. Three key areas that directly impact tobacco use are marketing strategies used by tobacco industries to promote their product, taxes on cigarettes, and prevention programs funded by states to combat tobacco use.

Marketing is the number one strategy utilized by the tobacco industry to sell their products to consumers, particularly younger people. Estimated annual marketing expenditures nationwide by the tobacco

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[201] Virginia Tobacco Settlement Foundation Office.

[202] Virginia Tobacco Settlement Foundation Office.

[203] Centers for Disease Control and Prevention. (May 22, 2007). *Smoking & Tobacco Use*. Retrieved July 9, 2007, from: http://www.cdc.gov/tobacco/data_statistics/Factsheets/SecondhandSmoke.htm.

[204] Centers for Disease Control and Prevention. (May 22, 2007). *Smoking & Tobacco Use.* Retrieved July 13, 2007, from: http://www.cdc.gov/tobacco/data_statistics/Factsheets/SecondhandSmoke.htm.

[205] Virginia Department of Health, Division of Chronic Disease Prevention and Control. *Tobacco Use Control Project*.

[206] Virginia Tobacco Settlement Foundation Office.

industry are $15.4 billion, which breaks down to $42 million per day. It is believed that the Virginia tobacco industry spends $438.5 million annually on marketing to encourage Virginians to use tobacco.[207]

There is a tax assessed on packages of cigarettes sold in every state. The average cigarette tax among all states is $1.073 per pack. New Jersey has the highest cigarette tax at $2.58 per pack.[208] Price has a serious effect on consumers, specifically on smoking use among teenagers. Generally as price increases, the number of youth who smoke decreases.[209] The Children's Health Insurance Program Reauthorization Act of 2007 (S-CHIP), is currently being discussed by the United States Senate. The federal government is exploring the prospect of increasing the national cigarette tax from 39 cents to $1 dollar per pack. If the federal government passes this proposal, the rate of smoking in the United States would likely decline. There would probably be a decline in Virginia, which could save the Commonwealth tobacco-related healthcare costs.

According to the Campaign for Tobacco-Free Kids, "In-state evidence shows that state cigarette tax increases are prompting many smokers to quit or cutback. For example, after the most recent cigarette tax increases in Michigan (from $1.25 to $2.00 per pack) and Montana ($0.70 to $1.70), calls to the state smoking quitlines skyrocketed. In the six months after the tax increase, the Michigan quitline received 3,100 calls, compared to only 550 in the previous six months; and in Montana more than 2,000 people called in the first 20 days after the tax increase, compared to only 380 calls per month previously."[210]

The final mechanism that significantly alters the rate of tobacco use in the United States is tobacco awareness and prevention programs. On average, the tobacco industry spends $28 on marketing and promotions for tobacco products for every $1 that states spend on prevention campaigns. The Virginia Tobacco Settlement Foundation (VTSF) is the leading prevention program in the Commonwealth. The VTSF was established by the Virginia General Assembly in 1999 to lead Virginia's youth tobacco use prevention efforts.

While increasing the cost of cigarettes and implementing prevention programs are individually effective strategies, a combination of the two yields the most promising results. "Combining tobacco tax increases with a comprehensive statewide tobacco prevention campaign will accelerate, expand, and sustain the tobacco use declines in the state, thereby saving more lives and saving more money. As an added bonus the state tobacco tax increases will provide the state with considerably more new revenues than the relatively small amount needed to fund a comprehensive state tobacco prevention program."[211]

Virginia Indoor Clean Air Act

The Virginia Indoor Clean Air Act (the Act) was first enacted in 1990 and has been amended several times since. The Act was created to reduce the exposure of Virginians to inhalation of secondhand smoke. The Act restricts smoking in some settings, including schools, school buses, hospital emergency rooms, commercial day care centers, and local health departments. It also enables many other public and private settings to determine their own restrictions on smoking. The Act does not ban smoking in the workplace nor in restaurants; however, individual company employers and restaurant owners have the

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[207] Campaign for Tobacco-Free Kids. (March 2006). *State-Specific Tobacco Company Marketing Expenditures 1988-2005.* Retrieved July 11, 2007, from: http://www.tobaccofreekids.org/research/factsheets/pdf/0271.pdf.

[208] Virginia Department of Health, Division of Chronic Disease Prevention and Control. *Tobacco Use Control Project.*

[209] Campaign for Tobacco-Free Kids. (March 2006). *Raising Cigarette Taxes Reduces Smoking, Especially Among Kids*. Retrieved July 13, 2007, from: http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf?zoom_highlight=Raising+Cigarette+Taxes+Reduces+Smoking.

[210] Campaign for Tobacco-Free Kids. (March 2006). *Raising Cigarette Taxes Reduces Smoking, Especially Among Kids*. Retrieved July 13, 2007, from: http://www.tobaccofreekids.org/research/factsheets/pdf/0146.pdf?zoom_highlight=Raising+Cigarette+Taxes+Reduces+Smoking.

[211] Campaign for Tobacco-Free Kids. (March 2006). *Tobacco Tax Increases Are Not Enough States Must Also Invest in Tobacco Prevention Programs.* Retrieved July 13, 2007, from: http://tobaccofreekids.org/search.php?zoom_query=Tobacco+Tax+Increases+are+not+Enough+States+must+Also+invest+in+Tobacco+Prevention+Programs.

discretion to implement smoking regulations. Signs must be posted, either "smoking permitted" or "no smoking," in these two settings to inform individuals of the guidelines. Currently, any restaurant that seats more than 50 people must provide a non-smoking section sufficient for demand.[212]

A smoke-free work environment would provide multiple benefits to the employer and the employees. Not only would the employer create a safe, healthy workplace, the employer could potentially receive numerous financial incentives for having a smoke-free workplace. The direct healthcare costs to the company may be reduced, the risk of fires is lower, and office equipment, including carpets and furniture will last longer. Employees of a small company will likely pay less for health coverage and insurance.[213]

Over the past several years, the General Assembly has considered legislation that would strengthen the provisions of the Virginia Indoor Clean Air Act by prohibiting smoking in any public place, including the workplace and restaurants. The supporters of this legislation have promoted awareness and made progress in their initiative to provide Virginians with a healthy, smoke-free environment, but such legislation has yet to become law. In the states and territories that have implemented comprehensive Clean Indoor Air Acts, the percentage of citizens effected by and the economic costs associated with secondhand smoke have significantly declined from the year prior to implementation, to the year immediately following implementation.[214]

WHY PURSUE POLICY CHANGE?

Promoting awareness of the harmful effects of tobacco use and providing tobacco use prevention programs are critical components in increasing the quality of life for all Virginians. Virginia's smoking-related healthcare costs exceed $2 billion annually. In 2005, $400 million of the state's Medicaid budget was allocated toward tobacco use disease control, a preventable lifestyle choice. The productivity loss in Virginia each year due to smoking amounts to $2.42 billion, while the average household pays $576 in taxes annually to cover the healthcare costs of smoking-related illnesses.[215] As Virginians become more cognizant of the financial ramifications associated with tobacco use and the reduced quality of life for individuals who use tobacco and suffer from secondhand smoke, citizens of the Commonwealth are more likely to curtail their usage of tobacco products. Reductions in tobacco use will have positive health impacts on the former smoker as well as the individuals who inhaled their smoke. Change will more likely result from an educated constituency. Also, policies and initiatives geared towards preventative measures will ensure the future quality of life for individuals who would have potentially become smokers without such programs.

RECOMMENDATIONS

The Quality, Transparency, and Prevention Workgroup (QTP Workgroup) of the Health Reform Commission (Commission) developed several recommendations concerning tobacco use in the Commonwealth. Both the QTP Workgroup and Commission had to narrow the number of recommendations to those that were felt to be of most importance. These recommendations can be broken down into what should be done for youth, the community, state employees, and Medicaid recipients. For a listing of all of the recommendations that were evaluated, please see Appendices N.

Recommendations for youth

A. The Virginia Department of Health (VDH) Tobacco Use Control Project (TUCP) currently fund coalitions and partners across the Commonwealth. These coalitions work with

[212] Virginia Department of Health, Division of Chronic Disease Prevention and Control. *Tobacco Use Control Project*.

[213] Virginia Department of Health, Division of Chronic Disease Prevention and Control. *Tobacco Use Control Project*.

[214] Virginia Department of Health, Division of Chronic Disease Prevention and Control. *Tobacco Use Control Project.*

[215] Centers for Disease Control and Prevention. (May 22, 2007). *Smoking & Tobacco Use*. Retrieved July 9, 2007, from: http://www.cdc.gov/tobacco/data_statistics/Factsheets/SecondhandSmoke.htm.

schools, colleges, workplaces, and other projects regarding tobacco use control policies. The VTSF and TUCP offer signage to promote tobacco-free school grounds for K-12 schools. School buildings are currently smoke free 24/7. VTSF and the American Lung Association of Virginia offer signs and stickers to public and private schools that adopt policies for their entire grounds. The adoption of a law to prohibit tobacco use on public school grounds would be highly effective.

- *The Governor through TUCP and VTSF should promote and create incentives for 24/7 tobacco-free K-12 school grounds.*

B. The VTSF and TUCP offer signage to promote tobacco-free campuses on centers for higher education. Small media campaigns are conducted on college campuses by each college. These media campaigns typically deal with tobacco use and cessation. Currently, some colleges have adopted smoke free policies for buildings and/or dorms. VDH funds college campaigns on a limited basis to promote awareness and policies. The adoption of a law to prohibit tobacco use on higher education campuses would be highly effective. Colleges may need technical assistance to implement smoke free policies and would require support from administration.

- *The Governor through TUCP should promote and create incentives for 24/7 tobacco-free higher education campuses.*

Recommendations for the community

A. TUCP currently funds coalitions and partners across the Commonwealth. These coalitions work to develop, implement, and advocate for policy change. Coalitions have been working with restaurants to go smoke-free. TUCP is working on a database to list all smoke-free restaurants from information gathered by the coalitions in the field. TUCP also works with partners (American Cancer Society, American Heart Association, and American Lung Association) to educate the public on the dangers of secondhand smoke and the need for smoke-free workplaces.

The Governor has directed the State Health Commissioner to work directly with interested parties to develop a recommended definition of “restaurant” for purposes of a smoking prohibition in restaurants, if adopted. This effort is currently in progress. At this time eighteen states and territories have passed Comprehensive Clean Indoor Air Acts. Multiple studies have found that smoke free ordinances have no negative impact on local businesses.

- *The Governor should introduce legislation to amend the Virginia Clean Indoor Air Act by prohibiting smoking in indoor spaces within restaurants throughout the state.*

B. The non-profit prevention collaborative (collaborative) discussed in the overall prevention recommendation should immediately begin work on enhancing the Virginia Department of Health’s quitline. VDH’s TUCP currently administers the QuitNow Virginia-tobacco user quitline with a budget of approximately $200,000. All of this funding comes from the Centers of Disease Control (CDC). The quitline is not allowed to supply nicotine replacement therapy and does not have a youth component. TUCP is working with quitline vendor regarding costs and development of cessation website and electronic quit packs.

In addition, state employees should be directed to use VDH’s quitline. By making QuitNow the quitline provider of choice for state health employees, funds that are currently be provided to CommonHealth could be redirected to QuitNow. In addition, the VDH and the collaborative should work with other stakeholders to make QuitNow the quitline of choice across the state.

- *The Governor should provide additional funding to the new non-profit prevention collaborative and the VDH to collaborate to enhance QuitNow by:*
  a. *Supporting an interactive tobacco cessation website and developing an electronic Quit Pack*
  b. *Developing a teen quit line*
  c. *Working with stakeholders to promote the use of one tobacco cessation line throughout the state*
  d. *Including nicotine replacement therapy as part of the quitline*
  e. *Requiring the state employee health plan to use QuitNow*

Recommendations for state employees and Medicaid recipients

A. Currently, the state employee health plan does not provide a premium differential for non-smokers, nor provide any type of financial incentive to quit smoking. Many employers across the country are looking to create benefit packages that incent and promote healthy lifestyles. While these types of programs may initially be burdensome to create, they are gaining popularity and the Commonwealth of Virginia should consider including these types of incentives in its benefit package.

   - *The Governor through the Department of Human Resource Management (DHRM) should create a benefits package that rewards non-tobacco using state employees for living a healthy lifestyle by offering a discount on the employee portion of their premium.*

B. The "Breaking Free from Tobacco" program is currently offered to state employees and family members at no cost through the CommonHealth wellness program. Smokers who want to quit may call a toll-free number twice during their lifetime to receive counseling from a health coordinator, a quit kit, and either an 8-week supply of nicotine patches or nicotine gum to help them break the smoking habit. Since its inception in FY 2003, an average of 1100 smokers per year have taken advantage of the program. Smoking cessation drugs are not covered under the program.

   The use of tobacco use deterrents with a behavioral support or modification program increases the likelihood of successful smoking cessation. Most patients are able to quit smoking by the 12th week with the aid of a smoking deterrent product. For patients taking varenicline (Chantix®) who successfully stop smoking at the end of the 12 weeks, an additional 12 week course is recommended to further increase the likelihood of abstinence.

   - *The Governor through the Department of Human Resource Management should expand nicotine replacement therapy in State Health Plan.*

C. As noted above, the "Breaking Free from Tobacco" program is currently offered to state employees and family members at no cost through the CommonHealth wellness program. Smokers who want to quit may call a toll-free number twice during their lifetime for counseling from a health coordinator, a quit kit and either an 8-week supply of nicotine patches or nicotine gum to help them break the smoking habit.

   Changing the opportunity to participate from twice to four times in an individual's lifetime would entail approximately an 8 percent increase in the cost to the health benefits program each year. About one-quarter of those who enroll in the program the first time then enroll a second time. The DHRM forecasts a 10 percent participation rate for third time and 3 percent participation rate for the fourth time. The cost to the health benefits program and the reduced number of participants over time should be weighed against the approximately $2,000 - $5,000 yearly reduced healthcare expenditures for each individual who quits smoking, that person's increased productivity as a result of better health, and the difficulty that many people have breaking the tobacco habit. Based on the rate of return in personal

health and financial savings, a third and fourth opportunity to the smoking cessation program should be added to the state employee health benefits package.

- *The Governor through the Department of Human Resource Management should increase the number of opportunities for state employees to participate in smoking cessation programs from two to four opportunities.*

D. State employees receive tips on smoking prevention and information from the "Breaking Free from Tobacco" smoking cessation program through CommonHealth wellness program, health educators, agency coordinators and various communications avenues such as newsletters, e-mails, and Web sites. Smoking cessation was highlighted in fall 2006 as part of the Governor's Healthy Virginians initiative, with a Web information campaign focused on the "Great American Smokeout" in November.

The Department of Medical Assistance Services (DMAS) covers the various pharmacotherapies (nicotine gum, nicotine patch, nicotine nasal spray/inhaler) for all recipients and Zyban for pregnant women and recipients under age 21 (through Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Program). In addition, DMAS covers counseling therapy for pregnant women through the prenatal patient education component of the Baby Care program and for EPSDT recipients (with prior authorization). DMAS does not cover telephonic counseling. DMA limits coverage of counseling sessions to six group sessions per year. There are no other limitations.

- *The Governor through the Department of Human Resource Management and the Department of Medical Assistance Services should Educate both State Employees and Medicaid beneficiaries about smoking cessation benefits available to them.*

ESTIMATED COSTS

Table 1: Pricing of Tobacco Use Recommendations (Annual Estimated Costs)

1A. Promote and create incentives for 24/7 tobacco-free K-12 school grounds	$ 90,000
1B. Promote and create incentives for 24/7 tobacco-free higher education campuses	$ 500,000
2A. Introduce legislation to amend the Virginia Clean Indoor Air Act by prohibiting smoking in indoor spaces within restaurants throughout the state	$ 0
2B. Provide additional funding to the new non-profit prevention collaborative and VDH to collaborate to enhance QuitNow	$ 3,000,000
3A. Create a benefits package that rewards non-tobacco using state employees for living a healthy lifestyle by offering a discount on the employee portion of their premium	Renegotiate contract to remain price neutral
3B. Expand nicotine replacement therapy in State Health Plan	$ 5,800,000
3C. Increase the number of opportunities for state employees to participate in smoking cessation programs from two to four opportunities	$ 30,000
3D. Educate both State Employees and Medicaid beneficiaries about smoking cessation benefits available to them	$ 0
Total	**$ 9,420,000**

INTRODUCTION

The Commonwealth must help all Virginians navigate the system of long-term care and advance the affordability, accessibility, and quality of long-term care for seniors and persons with disabilities. The Long-Term Care (LTC) Workgroup held eight sessions over six months to develop recommendations for consideration by the Health Reform Commission. The Workgroup was tasked with examining the direction of long-term care services and delivery systems in Virginia. The Workgroup elected to define long-term care as a system of policies and programs that provide social, health, and related supportive services such as housing and transportation to individuals of all ages who are limited in their ability to function over an extended period of time. The Workgroup representatives were from nursing facilities, assisted living, the mental health community, AARP, county government, managed care, and other areas. Members were either Governor-appointed Commission members or invited to participate in the Workgroup because of their expertise in specific areas of the long-term care arena. All members had equal participation in the Workgroup.

BACKGROUND – LONG-TERM CARE

The number of older Virginians is expected to increase substantially over the next 25 years. By 2010, persons over aged 60 will comprise 18 percent of the state's population.[216] By 2030, one in four Virginians will be over the age of 60; this is a 120 percent increase from 2000.[217] At the same time, the population of people with both physical and mental disabilities continues to grow; creating additional care needs, with higher morbidity.[218] In addition, Virginia's population as a whole continues to see increases in the number and types of co-occurring preventable conditions such as diabetes, obesity, and cardiovascular disease, all of which contribute to higher disability rates. Collectively, these growing needs will be a significant challenge for the Commonwealth and the nation.

This momentous population shift is just beginning and it will significantly change the ways the Commonwealth, localities, and long-term care providers offer care in Virginia. For the last decade, another force has been changing the way long-term care is delivered. The U.S. Supreme Court decision in *Olmstead v. L.C.* accelerated the growth in home and community-based services for persons needing long-term care. Today, long-term care consumers are choosing to remain in their homes or their community as long as possible. The Commonwealth has made significant changes in its Medicaid program to increase the number, type, and availability of home and community-based services. Virginia is also working to support more residents of state facilities in their transition to home and community-based settings. This shift toward community-integration has driven demand for more high quality and cost-effective long-term care in the community and changed the way Virginia's public and private providers and payers offer long-term care.

The demographic trends and continued drive toward home and community-based services has created and will continue to be a significant challenge for Virginia.[219] Many stakeholders and consumers believe all citizens of Virginia, regardless of age or income, have the right to make an informed choice about

[216] Joint Legislative Audit and Review Commission. (January 2006). Analysis of US Census Bureau Interim State Population Projections contained in, "Impact of an Aging Population on State Agencies." House Document No. 10. Retrieved July 25, 2007, from: http://jlarc.state.va.us/

[217] Joint Legislative Audit and Review Commission. (January 2006). Analysis of US Census Bureau Interim State Population Projections contained in, "Impact of an Aging Population on State Agencies." House Document No. 10. Retrieved July 25, 2007, from: http://jlarc.state.va.us/

[218] Braddock, D et al. "The State of the States in Developmental Disabilities 2005," University of Colorado, 2006 and National Association of State Mental Health Program Directors, Medical Directors Council, "Morbidity and Mortality in People with Serious Mental Illness," October 2006.

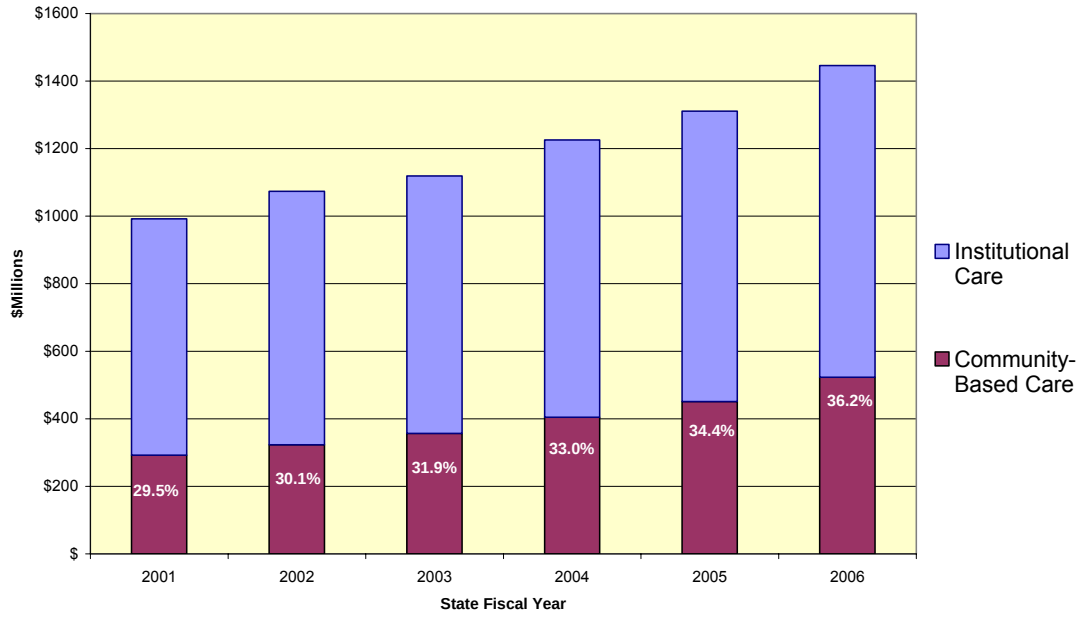
[219] Home and community-based options identified by the LTC Workgroup include, but are not limited to, home care, personal care services, assisted living, home healthcare, adult day healthcare, and Program for All-Inclusive Care for the Elderly (PACE).

where to live and receive services whether it be in an assisted living facility, their own home, or a nursing facility. The availability of services such as case management, wellness programs, and other community support programs are critical for people to live in community-settings as long as possible.

Medicaid Long-Term Care

Virginia's Medicaid program covers both institutional and home and community-based long-term care. The program is the primary public payer for long-term care services in Virginia. Reflecting the broad push toward community integration, Virginia's Medicaid program has made significant strides in increasing the availability of long-term care in home and community-based settings. Sixty-four percent of Virginia's current Medicaid long-term care expenditures are for care in institutions, a drop from 70 percent just five years ago (Figure 1).[220]

Figure 1: Community-Based Services as a % of Total Virginia Medicaid Long-Term Care



- *Long-Term Care in Institutions.* One of the Medicaid-covered institutional settings is a nursing facility. Nursing facility care is designed to provide a lesser level of care as compared to a hospital for those needing long-term nursing or convalescent care due to aging, injury, or illness. In 2005, there were 27,729 recipients of nursing facility services who qualified for Medicaid. According to the Joint Legislative Audit and Review Commission (JLARC), as of June 2005, there were 270 nursing facilities and 31,279 beds in Virginia certified for Medicare and Medicaid reimbursement and licensed by Virginia Department of Health. Medicaid also covers long-term care services provided in intermediate care facilities for persons with mental retardation (ICFs/MR) and care provided in long-stay hospitals.[221]

[220] Virginia Department of Medical Assistance Services. (December 2006). *Blueprint for the Integration of Acute and Long-Term Care Services*.

[221] Virginia Department of Medical Assistance Services. (December 2006). *Blueprint for the Integration of Acute and Long-Term Care Services*.

- *Long-Term Care in the Community.* The federal government allows Medicaid to pay for community-based services in lieu of institutional care through the use of 1915(c) home and community-based care service (HCBS) waivers. These waivers allow states to target services to specific populations that are at risk of institutional placement. Virginia currently operates seven Home and Community-Based Service (HCBS) waivers: the HIV/AIDS, Elderly or Disabled with Consumer-Direction (EDCD), Individual and Family Developmental Disabilities Support Waiver (DD), Mental Retardation (MR), Technology Assisted (Tech), Day Support (DS), and Alzheimer's.[222]

  These waivers provide a number of community-based services such as personal care, respite care, skilled nursing, day support, environmental modifications, and assistive technology. Individuals receiving waiver services may also consumer-direct some services, which mean the recipient is the "employer" and is responsible for hiring, monitoring and firing the care attendants. Services that allow for consumer-direction include personal care, respite, and companion care.

- *Program for All-Inclusive Care for the Elderly (PACE).* In addition to institutional care and HCBS waivers, Virginia currently has a pre-PACE provider located in the Hampton Roads area. This site will become a full PACE program in 2007, and several more PACE sites are expected to be developed over the next two years. PACE programs target individuals who are 55 years of age and older and who meet the criteria to enter a nursing facility. A full PACE program features a comprehensive service delivery system and integrated Medicare and Medicaid financing; pre-PACE integrates primary and long-term care services within Medicaid, but does not integrate Medicare financing and services.[223]

Other Public Long-Term Care Providers and Payors

Medicaid is just one public agency supporting long-term care delivery in Virginia. The Commonwealth has several other state agencies that play an important role in supporting long-term care. Currently, these agencies receive funding to provide a wide array of supportive services to seniors, people with disabilities, and family caregivers.

- *Virginia Department for the Aging (VDA).* VDA, through local Area Agencies on Aging (AAAs), provides a variety of services to older Virginians. Services might include adult day care, care coordination, elder abuse prevention, disease prevention and health promotion, home delivered meals, homemaker services, information and referral assistance, legal assistance, transportation, and respite care. Recently, VDA has also undertaken a "No Wrong Door" approach to the Commonwealth's long-term care system. Through grants to local AAAs, VDA is building a system of information for persons seeking long-term support. No Wrong Door will also enable local agencies to conduct eligibility screening for public programs and determine financial eligibility for Medicaid.

- *Virginia Department of Social Services (VDSS).* VDSS, through contracts with local Department of Social Services, completes Medicaid eligibility screenings, administers some local services programs for aging adults and also administers adult protective services, caregiver grants, and the auxiliary grant program. The auxiliary grant program provides supplemental cash assistance to qualified individuals who receive long-term care services in assisted living facilities. VDSS, through its central office, also licenses all assisted living facilities in Virginia.

- *Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS).* The Department provides services to people with intellectual and developmental disabilities as well as persons with mental illness and those suffering from substance abuse. Services

[222] Virginia Department of Medical Assistance Services. (December 2006). *Blueprint for the Integration of Acute and Long-Term Care Services*.

[223] Virginia Department of Medical Assistance Services. (December 2006). *Blueprint for the Integration of Acute and Long-Term Care Services*.

are provided in one of 16 state-operated facilities or through local contracts with Community Services Boards (CSBs). There are 40 such CSBs across the state that provide treatment, medication monitoring, crisis stabilization, and many other services.

- *Virginia Department of Health (VDH).* VDH provides a wide array of public health services to the community such as immunization, water quality, emergency preparedness, prenatal care, health screenings, and nursing home preadmission screenings. In addition, the VDH Office of Licensure and Certification inspects all Medicaid and Medicare-certified nursing facilities in the Commonwealth as well as home health agencies and hospice services.

- *Virginia Department of Rehabilitative Services (DRS).* DRS, provides many services to people with disabilities and some seniors who use long-term care services. DRS operates a personal assistance services (PAS) program that provides non-medical support with activities of daily living to consumers. In addition to the PAS program, DRS provides vocational rehabilitation services, assistive technology and equipment, and processes disability determination claims for the Social Security program.

Private Long-Term Care Providers

The private sector also has an important role in meeting the future demand for long-term care services. Private healthcare providers are working to meet the growing demand for services and develop innovative models to meet the needs of the new wave of long-term care consumers. These providers include nursing homes, assisted living facilities, home healthcare agencies, adult day care, and adult foster care programs. They also include county and local governments, non-profit housing development corporations, Centers for Independent Living, AAAs, Senior Navigator, and many other stakeholders who provide services on daily basis to seniors, people with disabilities, and family caregivers. Services provided by these providers include basic church meal programs to daily nursing care to sophisticated housing rehabilitation projects.

Private providers deliver much of the hands on long-term care that is paid for or facilitated through public programs such as Medicaid or the Older Americans Act. While a description of each of these types of providers is outside the scope of this section of the report, these providers have heavy interaction with public long-term care providers and payors. Many long-term care services are provided directly to consumers through these private organizations and they are a critical element of the long-term care system. The LTC Workgroup heard from many of these stakeholders during its deliberations and has considered the impact any recommendations might have on these entities.

Family Caregivers

Family caregivers are the dominant care provider for those in need of long-term care services. There are currently 700,000 estimated informal caregivers in Virginia providing 793 million caregiving hours each year at an uncompensated value of $8 million dollars per year.[224] The critical role of family caregivers in the long-term care system is often overlooked as is services to educate and support family caregivers. The National Family Caregiver Support Program, funded through Title IIIE of the Older Americans Act, provides support to these caregivers in the form of subsidies, education, and respite care. Respite care enables caregivers to be temporarily relieved from their care giving responsibilities and allows the caregiver time off to rest or take care of their own needs. The Commonwealth also provides several respite and other assistance programs through VDA, VDSS, as part of Medicaid home and community-based waivers, to assist family caregivers.

WHY PURSUE POLICY CHANGE

The LTC Workgroup believes long-term care consumers, whether frail elderly or persons with disabilities, should receive care in the most desirable setting possible and have a choice of home, community, or facility-based options that deliver high quality, effective medical care and social supports. This vision should guide the provision of long-term care in the Commonwealth, and:

- Enhance consumer choice;

[224] William L. (April 2, 2007). Presentation to the LTC Workgroup.

- Increase home and community-based care options;
- Enhance flexibility of funding streams, both federal and state, for local communities, agencies, and providers;
- Maximize family supports;
- Improve efficiency and quality of services to enhance quality of life; and
- Encourage Virginian's to be personally responsible for their future long-term care needs.

Virginia's challenge is to facilitate maximum consumer choice for all long-term care consumers in the state while meeting growing demands for services. Given the anticipated increase in the aging population and persons with disabilities and their corresponding need for long-term care services, Virginia must ensure that there is an adequate supply of quality, safe, and effective home and community-based options for persons who choose these settings. In addition, Virginia must continue to encourage and support improvements in care for institutional long-term care providers. High quality effective care in any long-term care setting includes a well-trained and adequate workforce, appropriate housing placement, and high quality supportive services. These efforts will require cross-agency collaboration and public-private sector collaboration to ensure proven best-practice models are identified and replicated wherever possible.

RECOMMENDATIONS

Given the scope of long-term care populations and services in the Commonwealth, the LTC Workgroup focused it's evaluation on seven major issues areas. The Workgroup selected these areas based on perceived needs and challenges for Virginia's long-term care sector. The areas are not mutually exclusive; they represent specific and sometimes overlapping gaps in the continuum of care available to Virginia's long-term care consumers. The areas were:

h. ***How can Virginia improve the information platform for long-term care consumers, families, and providers?*** Consumers of long-term care services and their families should have easy access to information about all care options. Providers should be able to access information about complementary services or options when consumers are in need.

i. ***How does Virginia encourage people to plan for their future long-term care needs?*** More effort should be placed on educating Virginians about long-term care planning to increase overall awareness and reduce further pressure on public resources. Employers and the Commonwealth should offer incentives to encourage individuals to invest in private long-term care insurance or other long-term care investment products.

j. ***How can providers, localities, and the State provide better care coordination?*** The integration of Medicaid acute and long-term care through managed care is a critical step in improving care coordination and financing for long-term care. Integration would allow for more flexible funding to meet long-term care consumers' needs and foster more seamless, coordinated care, including case management services. In addition, there is a need for better care coordination across all state programs for consumers of long-term care services, at both the state and local levels, for both policy and service delivery.

k. ***How can the Commonwealth increase access to affordable housing and improve housing supports?*** There are inadequate supports and unaffordable housing options for seniors and persons with disabilities who wish to live in the community. This reality prevents many of the elderly from "aging in place," and people seeking discharge from institutions are unable to locate adequate low-income housing.

l. ***Can the state and localities increase mobility in the community for long-term care consumers through more accessible and available transportation?*** Without accessible transportation, seniors and people with disabilities find it difficult to live in the community. Mobility options are key to successful in-home and community living.

m. ***How can providers, the educational system, and the Commonwealth foster the development of a qualified and adequate LTC workforce?*** There are an inadequate number of nurses, nursing support, and direct care workers in the long-term care sector in both rural and urban areas. This has created shortages that are likely to get worse as the demand for long-term care rises. The training, education, and qualifications of long-term care workers must also be improved. In addition, more geriatricians, nurse practitioners, and physician assistants are necessary to provide care to long-term care consumers.

n. ***How can Virginia, in concert with providers and localities, increase the number of community-living options?*** More community options must be made available to all seniors and persons with disabilities. An adequate spectrum of care should be provided. Consumers using long-term care services and their families should have a choice of care options. Home and community-based care options can be enhanced for those needing long-term care with better provider reimbursement rates and smarter regulation. These tools can also be paired with appropriate monitoring systems to improve overall quality of care. Families who are primary caregivers should also receive all the support needed to continue their caregiving and delay institutionalization of consumers as long as feasible and appropriate.

The LTC Workgroup made five consensus recommendations based on their evaluation.[225] This section of the report provides an overview of the recommendations. Detailed explanations for each recommendation are outlined in Appendix O.

Support and Expand Services for Low-Income Long-Term Care Consumers

Virginia should continue to build a well-developed infrastructure to provide long-term care services to low-income citizens in their homes and the community. This includes continued enrichment and development of the Medicaid program for persons with disabilities and frail elderly as well as additional regulatory and financial support for VDA, VDSS, and other agencies that provide supports to low-income people in need of long-term care services. Currently, 36 percent of Medicaid long-term care expenditures are for home and community-based care. This is an increase from less than 30 percent in 2001.[226] Virginia should continue to pursue policies that accelerate this trend.

- *The Governor, through the Secretary of Health and Human Resources, should ensure that 50 percent of Virginia's Medicaid long-term care expenditures are for home and community-based services by 2012.*

To reach this benchmark, both Medicaid program design and financial incentives should be improved. The LTC Workgroup recommends:

1a. Supporting the integration of Medicaid and Medicare acute and long-term care services for seniors and persons with disabilities through regional managed care models and continuing expansion of PACE programs;
1b. Maximizing consumer choice for Medicaid long-term care consumers by continuing to provide consumer-directed options;
1c. Providing an annual, automatic inflation update for Medicaid community providers, similar to nursing facility and home health reimbursement;
1d. Increasing overall Medicaid reimbursement rates to personal care and private duty nursing providers; and
1e. Adding assisted living as a Medicaid Elderly and Disabled with Consumer Direction (EDCD) waiver service.

[225] The LTC Workgroup elected to outline their concerns with the direct care workforce for the Workforce Workgroup's consideration. The concerns were outlined in a memorandum to the Workforce Workgroup (Appendix P).

[226] Virginia Department of Medical Assistance Services. (December 2006). *Blueprint for the Integration of Acute and Long-Term Care Services.*

1f. Expanding Medicaid case management for low-income seniors and persons with disabilities prior to meeting the criteria for nursing facility care
1g. Improving the VDSS auxiliary grant program.

Create Accessible and Affordable Housing for LTC Consumers

Virginia's frail elderly, people with mental illnesses, and people with physical, intellectual, and developmental disabilities have inadequate housing options across the Commonwealth. People who wish to remain in their homes have difficultly finding the services and supports they need to make their homes safe and functional. People who wish to leave nursing facilities, training centers, mental health institutions, or other facilities find it difficult to find affordable and safe housing to make their transition to the community. Despite these unmet needs, there are many organizations such as AAAs and housing development organizations that work closely with localities to develop successful models in their areas using blended federal, state, and local funding streams.

- *The Governor should provide funding to create a State Housing Partnership Revolving Fund to support development of innovative supportive housing options for seniors and persons with disabilities.*

Ensure Consumers, Caregivers, and Families Have Adequate Information about LTC Services and Encourage Virginians to Plan for their LTC Needs

All of Virginia's citizens should have convenient access to information about existing long-term care providers, services, and assistance programs in a single location regardless of where they live in the Commonwealth. All of Virginia's citizens over the age of 50 should have a plan for their future long-term care needs and understand the existing supports Virginia provides to help them purchase private long-term care insurance, such as the long-term care insurance tax credits and deductibles. In addition, Virginians should learn about and understand the value of the LTC Partnership program and the LTC Ombudsman program.

- *The Governor, through the Secretary of Health and Human Resources, should develop policies to increase the number of Virginians with private long-term care insurance policies to 10 percent by 2012 and to identify and encourage other types of LTC planning.*[227]

To achieve the 10 percent goal, the LTC Workgroup recommends:

A. Expanding VDA's *No Wrong Door* initiative statewide by 2010;
B. Developing an ongoing social marketing campaign to increase the number of Virginians over age 50 with a long-term care plan and support the LTC Partnership; and
C. Support family and consumer rights through the LTC Ombudsman Program.

Improve Home and Community-Based Options for All Seniors and Persons with Disabilities

It is expected that there will be more than 1.3 million additional seniors and persons with disabilities in Virginia by 2030; this is a 120 percent increase from 2000.[228] Current demand for home and community-based services, whether you are a low-income citizen or middle class, is outstripping services and the increasing numbers of persons in need will exacerbate this problem. This trend in demand is reinforced by current community integration efforts that focus on people living and working in the least-restrictive setting possible.

[227] Current estimates indicate that approximately 3% of Virginians had LTC insurance in 2005, LIMRA.

[228] Joint Legislative Audit and Review Commission. (January 2006). Analysis of US Census Bureau Interim State Population Projections contained in, "Impact of an Aging Population on State Agencies." House Document No. 10. Retrieved July 25, 2007, from: http://jlarc.state.va.us/

- *The Governor should support additional state resources and funding for programs that will help all seniors and people with disabilities to live in their homes or communities.*

The LTC Workgroup recommends:

A. Additional funding for local mobility and AAA transportation programs; and
B. Increasing support, education, and funding for family caregivers and study the current network of community-based caregiver support organizations.

Improve State and Local Coordination

During the 2007 General Assembly Session, House Bill (HB) 2033 was passed. This legislation designates the Secretary of Health and Human Resources as the lead for coordinating and implementing long-term care policy for the Commonwealth. This position is tasked with working with the Secretaries of Transportation, Commerce and Trade, and Education, and the Commissioner of Insurance to facilitate interagency service development and implementation, communication, and cooperation.

- *The Governor should support the expanded role under HB 2033 for the Secretary of Health and Human Resources, and take steps to strengthen her role.*

The LTC Workgroup recommends:

A. Gubernatorial designation of the Secretary as the single point of accountability for long-term care planning and implementation in the Commonwealth;
B. Establishing a Long-Term Care Coordinating Council comprised of state agency heads, whose agency has service programs providing long-term care, to advise the Secretary;
C. Establishing a Long-Term Care Advisory Council to advise the Coordination Council (5b) and the Secretary; and
D. Supporting long-term care planning and coordination of services across human service, housing, transportation, and other agencies at the local level and provide funding to support planning activity.

The LTC Workgroup believes the Governor, General Assembly, state agencies, localities, and the private sector have an important role to play in supporting and funding many of these recommendations. In addition to General Assembly appropriation of state General Funds, the LTC Workgroup encourages the Secretary of Health and Human Resources to continue to take advantage of federal grants and other funding opportunities to develop innovative pilot projects and other programs that support these recommendations. This will help Virginia maximize alternative funding streams and bolster the state's commitment to innovation in this area. The recommendations, if effectively implemented, will:

- Reinforce Medicaid's current pathway to more integrated and consumer-driven long-term care;
- Expand the availability of the most fundamental aspect of community living—housing;
- Dramatically increase the number of people planning for their future long-term care needs;
- Provide consumers, providers, and caregivers with access to a seamless coordinated system of information and decision-making tools;
- Provide options to enhance quality of life and delay unnecessary or premature institutionalization; and
- Significantly increase the availability and scope of integral services for all seniors and persons with disabilities such as transportation, case management, and respite care.

ESTIMATED COSTS

It is important to note that the Workgroup recognized the significant additional costs attached to many of the recommendations in this report and the group's underlying vision. This document is intended as

roadmap for an improved long-term care system. There are items that should and can be implemented now with appropriate performance benchmarks to measure future impact. Other recommendations could be reasonably tied to key benchmarks and implemented over the next five, ten, to fifteen years. The LTC Workgroup strongly believes that by promoting enhanced consumer choice and community supports, significant cost-savings will accrue over time as people's entry into institutions are delayed or prevented.

Table 1: Pricing of Long-Term Care Recommendations (Annual Estimated Costs)

1A. Support continued integration of Medicaid and Medicare acute and LTC through PACE and managed care models	$ 0
1B. Maximize consumer choice for Medicaid LTC consumers by continuing to provide consumer-directed options (support Money Follows the Person)	($ 975,000)
1C. Provide annual inflation adjustment to all Medicaid home and community-based providers	$ 26,345,078
1D. Rebase personal care 10 percent and skilled/private duty nursing 10 percent	$ 15,789,908
1E. Add assisted living to the Medicaid EDCD waiver	$ 15,671,476
1F. Establish case management for low-income seniors and persons with with 2+ ADLs as a state plan option	$ 29,022,924
1G. Improve the AG program	$ 500,000
2. Support the creation a state housing partnership revolving fund with incentives to build housing and supportive services for people with disabilities or frail elderly	$ 5,000,000
3A. Expand No Wrong Door statewide by 2010	$ 2,000,000
3B. Develop an ongoing social marketing campaign to encourage LTC planning and support the LTC Partnership	$ 100,000
3C. Support family and consumer rights though the LTC Ombudsman Program.	$ 913,000
4A. Provide funding to AAAs to increase transportation options for seniors and persons with disabilities	$ 1,250,000
4B. Increase support and funding for family caregivers and study the current network of community-based caregiver support organizations	$ 2,500,000
5A. Gubernatorial designation of the Secretary as the LTC point of accountability	$ 0
5B. Establish a LTC Coordination Council	$ 0
5C. Establish a LTC Advisory Council	$ 0
5D. Require local long-term care councils to include housing, transportation, and other representatives in their LTC planning processes and establish a mechanism for reporting to the Long-Term Care Advisory and Implementation Councils	$ 0
Total	**$ 98,117,386**

INTRODUCTION TO PUBLIC COMMENT

Comments submitted to Governor Kaine's Healthcare Reform Commission (HRC) covered a wide range of issues. In total 383 comments were received by the HRC. Six hearings were held throughout the state and 135 individuals testified at these hearings. A considerable majority of comments submitted fell under the auspices of the different Workgroups comprising the Commission; however, seventeen submissions could not be classified. Additionally, there were a large number of comments (84) that addressed multiple areas, specifically: Medicaid, Dental Coverage, and Disability. These multi-faceted entries were counted towards the total number of submissions for each summarized group of comments. The comments were categorized by theme and focus and are summarized as follows:

- Access to Healthcare and Health Insurance
- Expansion of Medicaid/FAMIS
- Dental Coverage
- Mental Health Accessibility
- Long-term care: Community Integration and Home and Community Based Services
- Long-term care: Direct Support Professionals
- Nursing Workforce
- Tobacco Use
- School Breakfast and Lunch Program
- Infant Mortality

Table 1: Summary of Public Comment by Thematic Area

Area	Number of Comments	Percent of Total
Access to Healthcare	45	8.27%
Expansion of Medicaid/FAMIS*	120	22.06%
Dental Coverage*	99	18.20%
Mental Health Accessibility	14	2.57%
LTC—Community Integration and Home and Community Based Services*	115	21.14%
LTC- Direct Support Professionals	102	18.75%
Nursing Workforce	14	2.57%
Tobacco Use	3	0.55%
School Breakfast and Lunch Program	22	4.04%
Infant Mortality	10	1.84%
Miscellaneous	17	3.13%
Total Individual Submissions:	383	N/A
Total Submissions- Adjusted for multifaceted submissions:	544	100%

* Denotes Multifaceted Submission

ACCESS TO HEALTHCARE AND HEALTH INSURANCE

Comments:

There were 45 comments, either submitted by written correspondence or presented at the public hearings, regarding access to and coverage of healthcare. Numerous constituencies from all over the state submitted materials or gave testimony at the public hearings. Two key 'sub-themes' emerged from the comments submitted: a need for increased accessibility to affordable health insurance and an increased investment in and expansion of Virginia's safety net healthcare system.

Many respondents submitted statements in support of the HRC's recommendations regarding improving access to health coverage. They particularly noted the lack of affordable health insurance for low-income workers. The needs of the working uninsured are growing everyday. The numerous statements of

support for state-coordinated low-cost products and other types of affordable insurance emphasize this fact. Several comments were submitted in support of broad-sweeping reform to supply universal health insurance by the state. Also, others announced their support for an expansion of services offered by the Virginia Department of Health (VDH) to provide coverage to all uninsured Virginians.

Numerous healthcare professionals support reforms that would provide affordable health insurance to those with lower incomes. These doctors, nurses, and hospital administrators cited instances where uninsured patients would be admitted with serious, life-threatening conditions, which could have been prevented had they not avoided prior medical treatment for fear of lacking health insurance. The significant financial and personal health impacts associated with the absence of affordable health coverage demonstrate the need for reform to the current health insurance system in Virginia.

The most popular area of comment was access to healthcare via community health centers and outpatient free clinics. Currently, approximately 65,000 patients receive their healthcare through the free clinics in Virginia. Respondents noted that is a small percentage of the approximately one million uninsured Virginians, but when considered with respect to the overall burden of disease of these 65,000, the free clinics are providing care to a disproportionately large component of the neediest of Virginia's uninsured population.

Almost every submission referencing community health centers called on the HRC to recommend increases in safety net funding so that the services provided by such clinics can be maintained and expanded. Other commenters advocated for an increase in minimum wages for Virginians, which would in turn provide more individuals with an increased ability to purchase health insurance, seek preventive care, or purchase needed medications.

EXPANSION OF MEDICAID/FAMIS

Background:

Virginia's Medicaid program is one of the leanest in the country. Nonetheless, expenditures have increased at an annual rate of nearly 10 percent, from $2.5 billion in FY 2000 to nearly $5.0 billion in FY 2006. In FY 2004, Virginia Medicaid provided reimbursement for an average of 625,000 recipients per month at a total cost of $3.8 billion. In FY 2005, Medicaid payments increased to $4.4 billion

Comments:

There were 120 comments, either submitted by written correspondence or presented at the public hearings, pertaining to the Medicaid eligibility rates. Most comments supported the idea of increasing Medicaid eligibility for impoverished adults from the current restriction of twenty-seven percent of the federal poverty level (FPL) to 100 percent of FPL. Currently, Virginia ranks as one of the lowest states for Medicaid expenditure per capita (49^{th} out of 50).

A significant amount of support for raising income eligibility limits for those in need of prenatal care was also noted. Currently the maximum eligibility cap is 185 percent FPL. The majority of comments addressing this issue requested an increase to 200 percent FPL.

The third largest sub-theme of submissions addressed the issue of adding Medicaid coverage for legal immigrants who have been in the country for at least five years. Currently Virginia is one of only nine states that does not provide such coverage.

DENTAL COVERAGE

Background:

Poor oral health has been linked by research to a multitude of health problems; such as diabetes, heart disease, and adverse pregnancy outcomes. People with periodontal disease are one-and-a-half to twice as likely to suffer a fatal heart attack and nearly three times more likely to suffer a stroke than those with strong oral hygiene. Additionally, studies have indicated that chronic oral infections can foster the development of clogged arteries and blood clots, and periodontitis can make diabetes worse as diabetic patients with severe periodontitis have greater difficulty maintaining normal blood sugar levels.

The Commonwealth of Virginia currently ranks as one of the lowest states, in per capita Medicaid expenditures. Virginia is one of only eight states that does not provide any dental service to adults on Medicaid.

Proper dental healthcare is imperative for general physical health. Dental exams help detect a myriad of oral diseases and disorders. Many elderly and low income adults suffer from numerous dental problems that are directly related to their overall health. Research has proven a direct correlation between oral health and total health. Preventive dental care has become essential. Unfortunately, many low income families do not have access to quality dental care due to its exclusion from Medicaid coverage in Virginia.

Comments:

There were 99 comments, either submitted by written correspondence or presented at the public hearings, pertaining to dental care coverage. These submissions advocated for dental coverage for adults to the current list of Medicaid supported needs in Virginia. A majority of the submissions came from members of the dental care community who cited the health risks associated with a lack of dental care.

MENTAL HEALTH ACCESSIBILITY

Comments:

There were fourteen comments, either submitted by written correspondence or presented at the public hearings, pertaining to mental health. Those submissions dealing with mental health were varied in focus. However, two key areas overlapped: increasing Medicaid provider reimbursements and promoting the co-location and integration of mental health and primary care treatment.

Additional comments focused on the need to increase the availability of transportation for individuals in need. Transportation assistance will enable mental health intervention can be accomplished more readily. Others submitted testimony on the need for in-home assessment and treatment, instead of analysis in a remote setting.

A call to increase the availability of low-income housing for individuals with mental illness was also among the testimonies delivered. Housing is a critical issue for those suffering from a mental illness. Many believe more adequate, low-income housing would allow for more discharges from mental institutions. They also stress the importance of getting people back into the community to help them successfully complete their recovery.

Several individuals submitted comments on the Virginia Tech incident that occurred on April 16, 2007. These were requests for revisions to definitions of imminent danger as well as amendments to commitment laws.

LONG-TERM CARE – COMMUNITY INTEGRATION AND HOME AND COMMUNITY BASED SERVICES

Background:

It is expected that by 2030 Virginia will be home to more than 1.3 million additional seniors and people with disabilities; this is a 120 percent increase from 2000. Current demand for home and community-

based services, regardless of socioeconomic standing, is outstripping available resources; the increasing numbers of those in need of such services will exacerbate this imbalance.

Currently, 36 percent of Medicaid long-term care expenditures are for home and community-based care. This demand for community-based care is expected to grow. Comments requesting a provision of an annual, automatic inflation update for Medicaid community providers, similar to nursing facility and home health reimbursement, were also common.

Currently, there is a depressed rate of employment among Virginians with disabilities. According to statistics compiled by Cornell University in 2005, almost 60 percent of working-age Virginians with disabilities were unemployed. Those receiving federal disability benefits cite the risk of losing healthcare coverage as the primary reason seeking employment does more harm than good. Many would like to work, but fear they will lose Medicare coverage for those on Social Security Disability Insurance (SSDI) or Medicaid for those on federal supplemental security income (SSI).

Since 1997, over 80,000 people with disabilities in 32 states have been covered by Medicaid buy-ins, which enables individuals to work without losing essential healthcare coverage. People with disabilities may choose to remain on benefits in order to keep their healthcare under Medicaid. According to respondents, Virginia's buy-in appears to do little if anything for people on SSDI who make too much money to qualify for Medicaid. Several individuals urged the Commission to take a strong stand in support of healthcare coverage for people with disabilities that would not consign them to permanent dependence on poverty level disability benefits.

The issue of institutional bias concerns how Virginia treats low income individuals with disabilities who rely on SSI to survive. The federal benefit rate for SSI is $623 a month – an amount that is 76 percent of the FPL. In 2005, just over 116,000 low income individuals with disabilities received SS and 6,000 of these individuals received an additional state supplemental benefit. Virginia pays that optional supplement solely if the person on SSI resides in a "community institution," such as an assisted living or adult foster care setting. Those submitting comments feel that individuals in such a position should not be forced to live in an institution out of economic compulsion.

Comments:

There were 115 comments, either submitted by written correspondence or presented at the public hearings, regarding housing and access issues associated with long-term care. A very popular sub-theme to this group of submissions was a consistent urging to improve home and community-based options for persons with disabilities and the elderly.

Submissions also supported efforts to expand services for low-income long-term care consumers. Respondents shared the belief that Virginia should build a well-developed infrastructure to provide long-term care services to low-income citizens in in-home and community-based settings. This includes continued enrichment and development of the Medicaid program for persons with disabilities and frail elderly, as well as additional regulatory and financial support for the Virginia Department for the Aging (VDA), the Department of Social Services (DSS), and other agencies that provide support to low-income people in need of long-term care services.

Comments were also received requesting increased funding of the DSS auxiliary grant program so that more assisted living facilities will be able to effectively care for those in need. These requests were often linked to calls for increases in the availability of adult day healthcare programs, an inexpensive alternative to institutionalization.

Comments regarding the need for an increase in workforce development relevant to geriatric care were also received. Many of these comments were duplicates or shared similar views with those summarized in the Nursing and Direct Support Professionals comments section of this report. Additionally, a few submissions called for increased oversight and regulation of quality respective to care in nursing homes and long-term care facilities.

Some respondents' comments addressed other issues, such as the need for increased availability and shorter waitlists periods for those seeking Medicaid Mental Retardation support (MR) waivers. Other individuals suggested the use of Brain Injury waivers for Medicaid support. Also, there was support for reforming the manner in which individuals' disabilities are assessed with respect to screening for eligibility of Medicaid reimbursement. The requests specifically call for a substitution of functional assessment in a daily living environment for the outdated medical nursing need requirement.

LONG-TERM CARE – DIRECT SUPPORT PROFESSIONALS (DSPS)

Background:

One of the problems facing consumers of personal care services is the high turnover of qualified workers, due to inadequate benefits, training, and wages. To have quality care for seniors and people with disabilities, consumers and their caregivers must be able to build relationships and establish a continuity of care. With turnover rates of in-home care averaging upwards of 40 percent, the continuity of care for consumers is jeopardized.

DSPs provide hands-on care to consumers, yet they do not have health insurance for themselves or their families, nor do they receive standard benefits commonly available to other healthcare workers, such as sick leave and vacation days. While DSPs receive hands-on instruction from the consumer on the consumer's day-to-day care, they rarely receive formal training.

Currently, Virginia ranks 45th lowest in wages for DSPs nationally and the state is expected to need thousands of additional direct support professionals in the coming years as the current population ages. As the elderly population increases in Virginia, the supply of available DSPs, which is already stretched to its limits, is expected to decrease.

Comments:

There were 102 comments submitted, either by written correspondence or presented at the public hearings, regarding the turnover rate, compensation, and benefits of DSPs serving in Virginia. The group of individuals submitting comments was largely comprised of recipients of care, their family members, and DSPs.

Multiple comments addressed issues facing those receiving care. Currently, the consumer in the DSP market is responsible for finding a caregiver, coordinating employment, and training the worker. If their DSP becomes sick, the consumer is often left to find a replacement or substitute caregiver.

A common theme among the comments submitted is that the shortage in DSPs providing direct care is projected to become more severe as the population ages.

NURSING WORKFORCE

Background:

The shortage of registered nurses (RNs) and other allied health professionals is a critical workforce issue that the Commonwealth needs to continue to address and emphasize through policy, legislation, and budgetary decisions. As Virginia's population above age 65 increases, so does the demand for qualified nurses. At the same time, factors both within and outside the healthcare profession has made increasing the supply of nurses and nursing faculty difficult. Combined, these factors have left Virginia with an ever-growing nursing shortage.

Statewide and regional studies have shown that the Commonwealth needs 1,614 additional RNs each year to meet growing demand. If no action is taken, it is believed that by 2020 the Commonwealth will

have a shortage of approximately 23,000 RNs. A significant majority of comments noted how nurses play a critical role within the healthcare community. They believe meeting the existing and future demands for nurses is vital to the stability of Virginia's healthcare system.

Comments:

There were fourteen comments, either submitted by written correspondence or presented at the public hearings, pertaining to the nursing workforce community. Commenters believe that efforts need to be taken to address the ever-increasing shortfall in the nursing and nursing assistant workforces.

Respondents were concerned that the relatively low wages RNs in Virginia receive are not at a competitive level to retain new nurses in the Virginia workforce or keep seasoned professionals from working in North Carolina. Concerns were also aired by nurses who work as state employees. They believe government wages are not competitive with the private sector and that such disparities are driving a migration of nurses from already understaffed state facilities to higher-paying private sector.

Constraints on nurse practitioners were another area of concern. Nurse practitioners are currently limited in the scope of their practice, despite education and training beyond what statutes define. As the healthcare needs of the Commonwealth grow, so will the need for more productivity from this growing source of healthcare providers.

General issuances of support for the Commission's recommendations for expansion of the nursing workforce were included in the submissions of a majority of respondents. Professional organizations such as the Virginia Nurses Association and the Virginia Council of Nurse Practitioners also support the recommendations put forward by the HRC.

TOBACCO USE

Background:

Tobacco remains the number one preventable cause of death in Virginia. Each year more than 9,000 Virginians die as a result of tobacco use, a lifestyle choice. Tobacco costs Virginia approximately $1.92 billion in healthcare bills each year, of which $369 million fall under Medicaid. A substantial portion of taxpayer dollars are used to cover expenditures incurred by the government from smoking-related illnesses. Each year, the average Virginia household pays $593 to cover smoking-attributable illnesses. It is estimated that economic costs of smoking are roughly $3,391 per smoker.

Comments:

There were three comments, either submitted by written correspondence or presented at the public hearings, pertaining to tobacco use in the Commonwealth. These individuals are in support of raising awareness of the health and financial implications of tobacco use. Providing Virginians with a greater awareness of the severity of tobacco use is a necessary element in curbing the use of these products.

These comments noted several recommendations, which are also the initiatives supported by the Virginia Tobacco Settlement Foundation, to help lower the use of tobacco. The first is to increase the state tobacco tax and dedicate the additional revenue to prevention and cessation programs. Virginia currently has the lowest tobacco tax of all states in the region, and it has been proven that taxing tobacco discourages teenagers from beginning to smoke. Second, Virginia should continue to allocate funding for teen smoking prevention and cessation; this will lower future tobacco-attributable healthcare costs in the Commonwealth. Finally, Virginia should provide funding for a tobacco cessation telephone counseling hotline available to both teens and adults. This would be an effective and convenient mechanism to help individuals quit using tobacco.

SCHOOL BREAKFAST AND LUNCH PROGRAM

Background:

Unlike other states, Virginia has never put into practice per meal funding for the school breakfast program. However, in 2005 the Virginia Department of Education (DOE) implemented a funding incentive to help defray the cost of additional breakfasts served. There has been nearly a 16 percent increase in the number of breakfasts served since the program's inception. A per meal incentive, as opposed to a new meal inducement, would supply the school systems with the financial support to offer nourishing foods, such as yogurt, fresh fruit, and whole grain breads.

Virginia began funding the school lunch program during the 1980-1981 school year, at a flat rate of $5.8 million per year. The Commonwealth has never supplied more than the federally required minimum for the school lunch program. The funding has not increased since 1980, but the number of lunches served continues to rise annually. Because the state's participation is at a fixed rate, as the schools serve more lunches, the percentage covered by the state decreases. In 1995, an average of more than 6 cents per lunch was absorbed by the state, while this number dropped to only 4.77 cents in 2006.

Virginia would likely see favorable changes in the overall health and performance of the students if more nutritious foods were available. Now more than ever, unhealthy foods are extremely inexpensive and available; whereas, fresh fruits and vegetables are becoming more costly. An increase in state funding would enable breakfast and lunch programs to compensate for the added expenses accrued by providing healthy foods.

Comments:

There were 22 comments, either submitted by written correspondence or presented at the public hearings, pertaining to increased funding for the school breakfast and lunch program. Allocating additional funding from the state for school breakfasts and lunches is identified as one of the top ten strategies in addressing the obesity epidemic.

Several reoccurring recommendations were suggested by the speakers as a starting point to address under funded school breakfast and lunch programs. The first request is for the DOE to increase the breakfast incentive program. Second, the state should provide a $0.05 compensation for each breakfast served to alleviate some of the financial costs. Finally, the existing flat rate of $5.8 million allotted for the school lunch program should be replaced with a $0.10 state reimbursement for each lunch served.

INFANT MORTALITY

Background:

The national infant mortality rate (IMR) is 6.9 deaths per 1,000 births, but Virginia's current IMR is 7.4 deaths per 1,000 births. Premature birth and low birth weight are the two primary causes of infant mortality. In Virginia, the preterm delivery rate is 12 percent, while the low birth weight is 9 percent. In order to meet the Healthy People 2010 US Objectives, the IMR must be reduced to 4.5 deaths per 1,000 births, preterm delivery to 7.6 percent, and infants of low birth weight to 5 percent.

Comments:

There were ten comments, either submitted by written correspondence or presented at the public hearings, pertaining to the increasing IMR in Virginia. These individuals support allocating additional funding to enhance the quality and accessibility of prenatal care and to help lower Virginia's IMR.

These are rather ambitious numbers, but respondents believe Virginia is capable of attaining this goal. The comments indicate that quality and accessible prenatal care are key components in lowering the IMR. Over one million of the seven million Virginians are uninsured. Many of the uninsured are

expectant mothers who lack proper prenatal care. A majority of those who commented on this subject spoke on behalf of Virginia's Chapter of the March of Dimes, an organization that focuses on promoting a healthy environment for infants. The four primary objectives of the March of Dimes are: to provide affordable healthcare for all pregnant women, infants, and children, to ensure coverage and benefits for all pregnant women who meet the clinical care guidelines established by the American Academy of Pediatrics, to create a plan for enhancing the number and distribution of maternity and pediatric providers, and to control methods to organize funding streams and assure quality care to ensure the wellbeing of the mothers, infants, and children.

The majority of the respondents recognized that Virginia has traditionally had a conservative Medicaid program. With that in mind, they proposed increasing eligibility for FAMIS MOMS to 200 percent of the federal poverty line. They also recommend expanding community-based home visiting programs, such as Resource Mothers and the Comprehensive Health Investment Project of Virginia, to promote awareness of and reduce the tendency of infant death. Finally, the speakers suggested aggressive outreach to register additional pregnant women into the Women, Infant, and Children Program, which is a successful initiative financed and implemented by the federal government.

APPENDIX A: EXECUTIVE ORDER 31

Establishing the Health Reform Commission

Importance of the Issue

Access to affordable, safe, high quality healthcare and long-term care are fundamental building blocks of a strong society. Virginians today face challenges in accessing healthcare, more than 1 million Virginians are uninsured and a growing shortage of health professionals of all types complicates access to care. While Virginia's health professionals are tremendously skilled and dedicated, more needs to be done to improve the quality and safety of patient care. Healthcare costs continue to rise, creating further strains on access to care and raising competitiveness issues for employers providing healthcare to their employees and retirees.

Health reform is a challenging undertaking, involving a wide range of valid, competing interests. Therefore, it is appropriate that leading voices on healthcare in Virginia be convened to make recommendations for reforming and strengthening healthcare in Virginia.

Creation of the Commission

By the power vested in me by Article V of the Constitution of Virginia, and Section 2.2-134 of the Code of Virginia, and mindful of the critical importance of this issue, I hereby create the Commission on Health Reform (the Commission) and direct it to begin work immediately. The Commission will be composed of 22 members, including state legislators, consumer and patient advocates, healthcare leaders, and citizen members. Additional members may be appointed at the Governor's discretion. The Secretary of Health and Human Resources shall chair the Commission. The Secretaries of Administration, Commerce and Trade, Education, Finance, and Technology, as well as the senior advisor for workforce shall serve as ex officio, voting members of the Commission. The Commission shall elect a vice-chair.

The Commission will have the following responsibilities:

1. Identifying and implementing national best practices in healthcare at the state level in terms of access to care, improving quality and safety of care, providing long-term care, and addressing affordability of care;
2. Working closely with the Joint Commission on Healthcare and fostering executive—legislative cooperation on healthcare issues;
3. Strengthening long-term care;
4. Forming, with appropriate other stakeholders, working groups on the uninsured, quality and safety of care, healthcare workforce, and long-term care;
5. Issuing a final report by September 1, 2007;
6. Holding public meetings or hearings as appropriate to allow for input into the Commission's work; and
7. Examining other issues as may seem appropriate.

Staff support for the Commission will be provided by the Governor's cabinet secretaries, the Governor's Office, and such agencies as shall be designated by the chair. All executive branch agencies shall cooperate fully with the Commission and provide any assistance necessary, upon request of the Commission or its staff.

Effective Date of the Order

This Executive Order shall become effective upon its signing and shall remain in full force and effect until July 20, 2007, unless amended or rescinded by further executive order. It is my intention to renew this commission for an additional year, as permitted by law.

Given under my hand and under the Seal of the Commonwealth of Virginia this 20th day of July 2006.

Timothy M. Kaine, Governor

Attest:

Secretary of the Commonwealth

APPENDIX B: HEALTH REFORM COMMISSION MEMBERS

2006-2007 Governor's Health Reform Commission Members

The Honorable Marilyn B. Tavenner	Secretary of Health and Human Resources, Chair
Mr. Julien G. Patterson	Omniplex World Services Corporation, Co-Chair
The Honorable William T. "Bill" Bolling	Lieutenant Governor, Commonwealth of Virginia
The Honorable Anthony L. Burfoot	Norfolk City Council
Ms. Jan Lovelace Burrus	Glaxo Smith Kline
Mr. Henry Claypool	Independence Care System
Mr. Brian D. Coyne	AMERIGROUP Corporation
Dr. Terry Dickinson	Virginia Dental Association
Ms. Karen Drenkard	Inova Health System
Mr. Michael M. Dudley	Sentara
Mr. James N. Ellenberger	AFL-CIO Retirees Association
Dr. Arthur Garson, Jr. M.D., M.P.H.	UVA Health System
The Honorable Franklin P. Hall	Virginia House of Delegates
Mr. David H. Hallock, Jr.	Kemper Consulting
The Honorable Phillip A. Hamilton	Virginia House of Delegates
Dr. Lorena Harvey	Family Practice Physician
The Honorable R. Edward "Edd" Houck	Senate of Virginia
Ms. Teresa M. Klaassen	Sunrise Assisted Living
Mr. William L. Lukhard	AARP
Mr. T. Carter Melton, Jr.	Rockingham Memorial Hospital
The Honorable Brian J. Moran	Virginia House of Delegates
The Honorable John M. O'Bannon, III M.D.	Virginia House of Delegates
Ms. Deborah D. Oswalt	Virginia Healthcare Foundation
The Honorable Linda T. "Toddy" Puller	Senate of Virginia
Mr. Sanjay Puri	Optimos
Dr. Sheldon M. Retchin, M.D.	VCU Health System
Mr. Craig R. Smith	Owens and Minor
Mr. Thomas G. Snead, Jr.	Virginia Healthcare Foundation
The Honorable Lionell Spruill, Sr.	Virginia House of Delegates
Ms. Nancy J. Stern	Eastern Shore Rural Health Systems
The Honorable Roslyn C. Tyler	Virginia House of Delegates
The Reverend L. William Yolton	Mental Health Advocacy
The Honorable William C. Wampler, Jr.	Senate of Virginia

APPENDIX C: HEALTH REFORM COMMISSION WORKGROUP MEMBERS

Workforce

Person	Position	Affiliation
Arthur Garson, Jr. M.D., M.P.H.	Chairman	UVA Medical School
Karen Drenkard	Co-Chair	INOVA
T. Carter Melton, Jr.		Rockingham Memorial Hospital
Julien G. Patterson		Omniplex
Sanjay Puri		Optimos
Peter Blake		Virginia Community College System
Steven J. Ashby, Ph.D		Richmond Behavioral Health Authority
Roberta Bernardini		Tidewater Community College
Teresa M. Haller		Virginia Nurse Association
Gerald Pepe, M.D.		Dean, EVMS
Joel Silverman, M.D.		VCU Health System
Maureen Schnittger		Western State Hospital

Access to Care

Person	Position	Affiliation
Sheldon M. Retchin, M.D.	Chairman	VCU Health System
Thomas G. Snead, Jr.	Co-Chair	Virginia Healthcare Foundation
Jan Lovelace Burrus		Glaxo Smith Kline
Anthony L. Burfoot		Norfolk City Council
Terry Dickinson, M.D.		Virginia Dental Association
Deborah D. Oswalt		Virginia Healthcare Foundation
Nancy J. Stern		Eastern Shore Rural Health Systems
Marlene Blum		Fairfax County Healthcare Advisory Board
Kay Crane		Piedmont Access to Health Services
W. Montgomery Dise		Asset Protection Group
Luis Eljaiek, M.D.		VA College of Emergency Physicians
John Little		Amerigroup
Michele Peters		Legal Aid Society of the Eastern Virginia
Dick Robers		Total Action Against Poverty (Roanoke)
Suzanne Sheridan		Rockbridge Area Free Clinic

Quality, Transparency, & Prevention

Person	Position	Affiliation
David H. Hallock, Jr.	Chairman	Kemper Consulting
Lorena Harvey, M.D.	Co-Chair	Family Practitioner
Michael M. Dudley		Sentara
Craig R. Smith		Owens and Minor
Chris Bailey		Virginia Hospital and Healthcare Association
Miriam (Mimi) Bender		Women's Health Virginia
Cynthia Cave, M.D.		Department of Education
Sallie Cook, M.D.		Virginia Health Quality Center
Nancy Farrell		Virginia Dietetic Association
James Forrester, Ed. D.		Sentara
Hobart Harvey		Virginia HealthCare Association
Braxton McKee		Virginia Bar Association
Becky Snead		Virginia Pharmacy Association

Long-Term Care

Person	Position	Affiliation
William L. Lukhard	Chairman	AARP
Brian D. Coyne	Vice-Chair	Amerigroup
Henry Claypool		Independence Care System
James N. Ellenberger		AFL-CIO Retirees Association
Teresa M. Klaassen		Sunrise Senior Assisted Living
L. William Yolton		Mental Health Advocacy
Michael Cook		Epstein and Becker, PC
Barbara Favola		Arlington County Board of Supervisors
Frank Hayes		Roanoke United Methodist
Jean S. Kane		Western State Hospital Advisory Council
Beth Ludden		Genworth
Richard Lyons		Immediate Past Chairman VHCA, Sunnyside Retirement Communities
Lisa Sprinkel		President of Board of Directors, Virginia Association of Home Care; Carilion Home Health

Note: Those names that are bolded are members of the Governor's Health Reform Commission

APPENDIX D: PHYSICIAN LOAN REPAYMENT PROGRAMS

Loan Repayment Program	Administration	Funding	Applicant Eligibility	Service Requirements	Practice Site Eligibility	Benefits
National Health Service Corps (NHSC) Loan Repayment Program	National Health Service Corps – Federal Level VDH, OHPP – Liaison between applicants and practice sites	National Health Service Corps – Federal Level	Fully trained… • Primary healthcare clinicians - MD, DO physicians, certified nurse midwives, physician assistants • Dental healthcare clinicians – general practice dentists, registered clinical dental hygienists • Mental healthcare clinicians – psychiatrists, clinical/counseling psychologists, clinical social workers, psychiatric nurse specialists, marriage and family therapists, licensed professional counselors	• Minimum of 2 years in full-time practice (40 hours/week, with at least 32 in ambulatory care) • Ob/Gyn and certified nurse mid-wives – 21 hours/week of outpatient clinical practice • Time spent on call does not count toward the 40 hours/week	• Public, nonprofit or private health facility • Services include comprehensive primary heath care • Serves individuals in a Health Professional Shortage Area • Must agree to treat all patients regardless of ability to pay for service http://hpsafind.hrsa.gov/HPSASearch.aspx	• For 1st 2 years – Pay up to $25K for each year of service, based on balance of qualifying loans • If loans = less than $50K, the program will pay 1/5 of the total annually
Virginia State Loan Repayment Program (VA-SLRP)	VDH, OHPP	Federal and State	Fully trained… • MD, DO physician with specialty of - family/general practice, general internal medicine, general pediatrics, obstetrics/gynecology or psychiatry or dentistis • Primary care physician assistant • Primary care nurse practitioner *Applications Accepted January 1 – May 1*	• Provide primary care services in a HPSA for minimum of 2 years – can extend for maximum of 4 years • US citizen • Valid, unrestricted VA medical license • Provide full-time services • Have completely satisfied any other service that is owed	• Public or private not-for-profit health facility • Must serve in a Health Professional Shortage Area • Must agree to treat all patients regardless of ability to pay for service; must accept Medicare/Medicaid	• Receive up to $50k for a 2-year commitment • $85K for a 3-year commitment • $120K for a 4-year commitment (tax exempt)
Virginia Physician Loan Repayment Program (VLRP)	VDH, OHPP	State	Fully trained… • MD, DO physician with specialty of - family/general practice, general internal medicine,	• Provide primary care services in a MUA or HPSA for minimum of 2 years – can extend for maximum of 4	• Must be in a Medically Underserved Area or in a Health Professional Shortage Area • Must agree to	• Receive up to $50k for a 2-year commitment • $85K for a 3-year commitment • $120K for a 4-

	general pediatrics, obstetrics/gynecology or psychiatry *Applications Accepted January 1 – May 1*	years • US citizen • Valid, unrestricted VA medical license • Provide full-time services • Have completely satisfied any other service that is owed	treat all patients regardless of ability to pay for service; must accept Medicare/Medicaid	year commitment (NOT tax exempt)

Aileen E. Harris, M.S.A, Incentives Coordinator ***** Ellen McCutheon, Program Support Technician
Virginia Department of Health | Office of Health Policy and Planning | Local: (804) 864-7435 |
http://www.vdh.virginia.gov/healthpolicy/healthcareworkforce/nursingscholarships.htm

APPENDIX E: LISTING OF ALL PHYSICIAN WORKFORCE RECOMMENDATIONS

Goal	Objectives	Strategies
1. Accurately measure the progress towards increasing supply and decreasing demand	A. On annual basis develop and/or assign accountability for collection and evaluation of workforce metrics to guide policy decisions	1. Fund ongoing analysis of currently available health professions workforce data at DHP 2. Implement a systems infrastructure that assures data collection and analysis on the supply & demand of healthcare workers 3. Provide annual physician workforce supply and demand reports to the Governor and General Assembly 4. Support more detailed collection by the BOM 5. Conduct a one-time funded review looking at where VA medical school graduates have gone post graduation and where VA residency program graduates have gone post residency 6. Facilitate centralized data collection and analysis to improve the quality and quantity of physician workforce data through DHP
2. Increase supply of physicians in the state by X doctors per year	A. Create conditions where current and future schools can increase capacity through facilities planning and program development	1. Request medical programs to submit strategic plans that identify enrollment capabilities and resource requirements to increase basic medical programs by X% through assignments to University Presidents A. Based on strategic plans developed, expand medical education facilities or B. Plan new facilities to accommodate the opening of medical programs 2. Provide grant funding to medical schools for implementing innovative practices that will change the medical educational model to produce additional and higher quality physicians
	B. Assist future students in obtaining resources	1. Increase funding for existing scholarship and loan repayment programs 2. Structure current and/or new loan repayment programs to include medical malpractice insurance, a median salary income with appropriate cost of living adjustments, practice management education/training, taxes etc. 3. Partner with localities and private sector to fund medical students and residents this could include salary, reimbursement for travel, malpractice, etc.
	C. Direct students towards difficult recruitment areas of the state	1. Create a State Health Service Corp model requiring practice in an underserved location 2. Expand the number of reimbursable telemedicine activities in Medicaid and for state employees, particulary store and forward capacity 3. Redefine Health Professional Service Shortage areas by funding more staff in VDH's Office of Health Policy and Planning (OHPP) 4. Establish a state-funded grant program to help underserved areas recruit and retain primary care doctors 5. Fund additional recruitment and marketing efforts in VDH's OHPP including increased staffing 6. Provide grants to primary care physicians in underserved areas who agree to teach residents

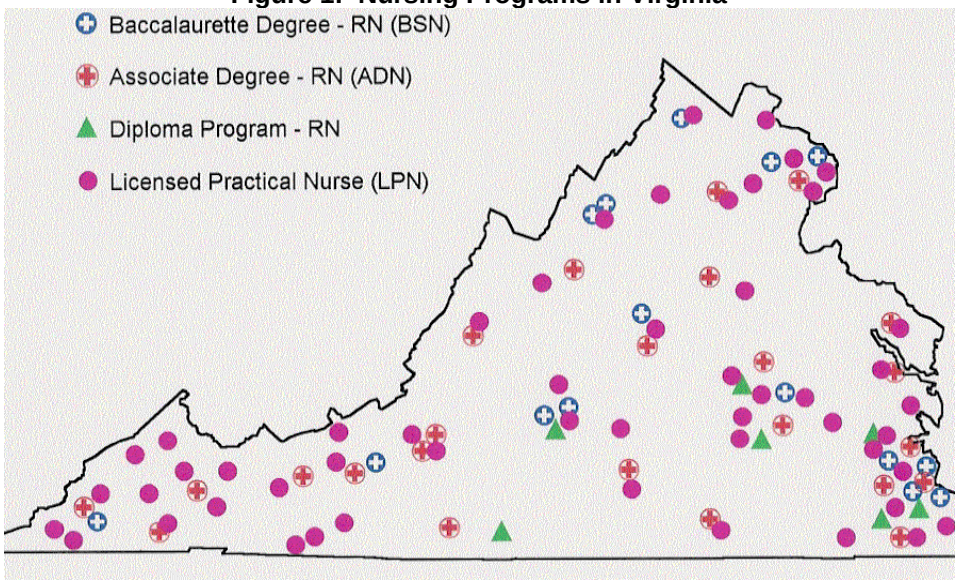
	D. Attract students to the medical profession	1. Create "competitive" payment for residents A. Provide a special focus to residents in rural hospitals 2. Prioritize the recruitment of ethnic minorities through funding, a public relations strategy targeting families and various media outlets, translation services, etc.
	E. Create conditions to increase capacity to enroll students through recruiting and retaining faculty	1. Provide funding to cover teaching time for physicians -- (e.g. 10 FTE per school to teach basic science and 25% increase in teaching hours for clinical undergraduate and graduate medical education)
3. Decrease demand by improving quality of work life and maximizing efficiency and expertise of physicians	A. Improve physician workflow through appropriate technology	1. Develop incentives for physicians to achieve computerized patient records (EHR/EMR) 2. Promote electronic billing and payment 3. Promote the use of telemedicine technology 4. Promote healthier lifestyles and compliance with medical recommendations (e.g. medication compliance)
	B. Promote utilization of physicians extenders	1. Create more physician extender programs in the Commonwealth 2. Change scope of practice to allow physicians extenders to do more 3. Provide grant funding to study physician / nurse teams
	C. Create and/or allocate funding to support physicians	1. Increase Medicaid rates for all physicians by X% 2. Increase Medicaid behavioral health provider rates by an additional X%

APPENDIX F: NURSING SCHOOLS ACROSS THE COMMONWEALTH

Table 1: Number of RN Education Programs in Virginia

Region	AD	BSN	Diploma	MSN	PhD
Blue Ridge	4	4	0	2	1
Central	3	1	2	1	1
Hampton Roads	4	4	2	3	1
Northern Virginia	2	2	0	2	1
Roanoke	4	4	2	2	0
Southwestern	3	1	0	0	0
Total	**20**	**16**	**6**	**10**	**4**

Figure 1: Nursing Programs in Virginia



APPENDIX G: NURSING SCHOLARSHIPS

Nursing Scholarship	Number of Applications Per Student	Scholarship Amount	Applications Accepted	Applicant Eligibility	Scholarship Conditions
Mary Marshall Nursing Scholarship for ***Licensed Practical Nurses***	• Scholarships are awarded for single academic years • No student may receive a scholarship for more than 4 years total	• Dependent upon funds appropriated by the VA General Assembly, money collected by Board of Nursing and number of qualified applicants	• May 1-June 30 for fall academic year	• Residency in VA for at least 1 year • Acceptance/ enrollment as a full-time or part-time student in a practical school of nursing in VA • Submitted a complete application and recommendation from Program Director	• Engage in full-time nursing in VA for 1 month for every $100 received • Obtain license within 60 days of graduating • Begin full-time employment within 90 days of licensure date • Voluntary military service cannot be used to repay scholarship awards
Mary Marshall Nursing Scholarship for ***Registered Nurses***	• Scholarships are awarded for single academic years • No student may receive a scholarship for more than 4 years total	• Dependent upon funds appropriated by the VA General Assembly, money collected by Board of Nursing and number of qualified applicants	• May 1-June 30 for fall academic year	• Residency in VA for at least 1 year • Acceptance/enrollment as a full-time or part-time student in a practical school of nursing in VA • Cumulative GPA of 3.0 in required courses, not electives • Demonstration of financial need, verified by financial aid office at school • Submission of a complete application and official transcript	• Engage in full-time nursing in VA for 1 month for every $100 received • Obtain license within 60 days of graduating • Begin full-time employment within 90 days of licensure date • Voluntary military service cannot be used to repay scholarship awards
Virginia's ***Nurse Practitioner/ Nurse Midwife*** Scholarship Program	• Scholarships are awarded for single academic years • No student may receive a scholarship for more than 2 years total	• Dependent upon funds appropriated by the VA General Assembly	• May 1-June 30 for fall academic year	• Residency in VA for at least 1 year • Acceptance/enrollment as a full-time or part-time student in a practical school of nursing in VA • Cumulative GPA of 3.0 • Submission of a complete application, official transcript, 2 reference letters, and a statement of intent to practice as a nurse practitioner/nurse midwife in an underserved area of VA following graduation	• Engage in full-time nursing in a MUA in VA for 1 year for each year a scholarship is received • Practice facility must agree to treat all patients regardless of ability to pay for service; must accept Medicare/Medicaid • Full-time employment must begin within 2 years of graduation date • Voluntary military service cannot be used to repay scholarship awards
Commonwealth of Virginia ***Nurse***	• Scholarships are awarded for single academic years	• Recipients will receive $20,000 per	• June 1-July 31 for fall	• Full or part-time graduate students in a master's or	• Teach in a Virginia school of nursing for 2 years for

Educator Scholarship Program	year, for up to 2 years while completing coursework	academic year	doctoral program in Virginia	every year a scholarship is received • Service must begin within 3 months of completing their educational program

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APPENDIX H: LISTING OF ALL NURSING WORKFORCE RECOMMENDATIONS

Goal	Objective	Strategies
1. Increase supply of RNs in the state by additional 900 nurses per year	A. Create conditions where current and future schools can increase capacity through facilities planning and program development	1. Request nursing programs to submit strategic plans that identify enrollment capabilities and resource requirements to increase basic nursing programs by 50% and 100% through assignments to University Presidents A. Based on the strategic plans developed expand nursing education facilities or B. Plan new facilities to accommodate the opening of nursing programs 2. Develop prelicensure and masters programs in the Commonwealth 3. Expand the number of nursing faculty positions 4. Develop accelerated nursing school programs for students with degrees in other fields 5. Build regional simulation centers 6. Increase the number of clinical training sites for students 7. Develop distance education programs/classes to deal with lack of facilities and faculty and increased interest in nursing 8. Provide grant funding to nursing schools for implementing innovative practices that will change the nursing educational model to produce additional and higher quality nurses
	B. Create conditions to increase capacity to enroll students through recruiting and retaining faculty	1. Raise faculty salary 15% each year for 3 years 2. Fund loan forgiveness programs for masters & PHD students requiring teaching for two years 3. Evaluate nursing faculty salaries regularly to assure market competitiveness 4. Develop and implement short-term post masters/post baccalaureate courses 5. Allow faculty to collect their full retirement while being paid for additional faculty service 6. Provide grant funds to hire retired faculty to provide tutoring and lab assistance to prospective nursing students 7. Implement additional PHD programs with an emphasis on education 8. Remove barriers for retired nurses concerning time limits prior to reentering the workforce
	C. Create and/or allocate funding to support nursing programs	1. Create general revenue support to fund nursing education through increased appropriations and block grants 2. Develop formula funding systems to allocate appropriated funds - "base adequacy" number increased 3. Fund nursing programs by using funds targeted for enrollment growth, economic development, tobacco settlement monies, and state-appropriated federal dollars 4. Use funds from the Workforce Investment Act for nurse entry-level worker training programs 5. Assign the WIBs to include nursing workforce issue as a focus area 6. Use Medicaid reimbursement to support graduate nurse education 7. Create dedicated state appropriations for nursing 8. Allocate a funding stream for nurse residency payment 9. Increase funding for existing scholarship and loan repayment programs prioritizing nursing faculty programs and racial and ethnic minority programs 10. Increase scholarships and loans available

	D. Assist future students in obtaining resources to enter nursing school	1. Provide grant funds and work with existing volunteer programs to create a comprehensive nursing career center within DHP 2. Create a web-based one stop shop that describes how to become a nurse at DHP 3. Establish a directory of scholarships with the goal of on-line application through a single website portal at DHP 4. Identify best practices through data center and disseminiate across the state 5. Evaluate regularly the need for expansion in nursing placements / student spaces / new nursing programs
	E. Direct students towards hard to fill nursing practice areas	1. Develop a loan forgiveness program requiring practice in an underserved area comparable to the federal HRSA program 2. Fund Virginia's Long-term care Scholarship 3. Develop incentives for nurses to enter behavioral health
	F. Improve graduation rates in all nursing programs	1. Recommend admission requirements for nursing programs be based on criteria correlated to graduation rates 2. Create a state supported life emergency loan fund for students i.e. funds for students who need help paying with daycare, buying books, etc.
	G. Evaluate baccalaureate educational capacity	1. Increase the size of existing bachelor's programs to allocate the additional 900 students needed per year and provide funding pursuant to recommendations in facilities planning and program development 2. Give community colleges baccalaureate degree granting authority and provide funding
2. Accurately measure the progress towards increasing supply and decreasing demand	H. On annual basis develop and/or assign accountability for collection and evaluation of workforce metrics to guide policy decisions	1. Fund ongoing analysis of currently available health professions workforce data 2. Implement a systems infrastructure that assures data collection and analysis on the supply & demand of healthcare workers 3. Provide annual nursing and healthcare workforce supply and demand reports to the Governor and General Assembly 4. Support more detailed data collection by the BON 5. Support improved data collection on health service utilization for all sectors of the health system 6. Facilitate centralized data collection and analysis to improve the quality and quantity of healthcare workforce data through DHP 7. Assign accountability for data review and workforce strategy development to DHP 8. Create a consortium, similar to Northern VA alliance, in each region of the state that works to increase healthcare workforce 9. Develop standardized data definitions for workforce data
	I. Lay the groundwork to continue increasing pipeline through marketing and developing educational programs to increase interest in nursing professions.	1. Fund a comprehensive nursing recruitment plan and identify state funding to support existing effective recruitment initiatives 2. Provide education concerning nursing education programs, educational requirements, and career opportunities in nursing through web portal at DHP 3. Establish magnet high schools in each region with an emphasis upon life sciences and healthcare disciplines 4. Disseminate public information about nurse career ladder articulation programs for nurses 5. Prioritize the recruitment of men as well as ethnic minorities 6. Create healthcare worker intake programs for immigrant and low-income communities 7. Revamp high school programs to include college credits for nursing while in high school

3. Manage demand for RNs in acute care settings	J. Incent healthcare providers for excellence in nursing	1. Use nurse-sensitive indicators to pay hospitals for nursing performance 2. Support technology to facilitate outcome measurements related to nurse-sensitive patient care indicators 3. Modify reimbursement methodologies to the direct reimbursement of nursing care so that revenues can be used to improve staffing levels 4. Offer reduced work opportunities to retirement-aged practicing nursing and faculty 5. Create a Virginia Nurse Recognition Program - Governor's Nurse Award
	K. Improve nurse workflow through appropriate technology	1. Develop standardized definitions for clinical data 2. Create a competitive grant process for improving work environment and/or patient safety 3. Develop incentives for hospitals and other healthcare agencies to achieve computerized patient records (EHR/EMR) 4. Assure RN representation on regional RHIO initiatives

APPENDIX I: LISTING OF ALL DIRECT SUPPORT PROFESSIONAL WORKFORCE RECOMMENDATIONS

Goal	Objective	Strategies
1. Increase supply of Direct Support Professionals in the state	A. Create and/or allocate funding to support direct support professional programs and workers	1. Assign the WIBs to include the direct support professionals workforce as a focus area 2. Fund pilot programs to increase One-Stop, local Departments of Social Services (DSS), and AHEC coordination. A. Use funds to increase the number of TANF recipients who enter the direct support professional workforce. B. Develop nurse entry-level worker training programs C. Develop career ladders for direct support professionals D. Implement cross-training programs for One-Stops and DSS workers to receive an understanding of both systems, respective incentives and differences E. Emphasize use of One-Stop System as part of a continuum of services for the TANF population F. Develop short-term intensive, integrated education and training programs to include an infusion of "soft skills" development G. Use a person centered approach to planning that incorporates upfront assessments to determine needs and interagency collaborative case management to provide a wide range of workforce and income supports 3. Implement permanent, annual inflation updates to Medicaid home and community-based provider rates 4. Replicate DMAS's Demonstration to Improve the Direct Service Community Workforce in six pilot sites across the Commonwealth
	B. Assist providers in increasing awareness about the direct support professional shortage and issues	1. LTC providers should be encouraged by the Governor' Workforce Advisor to work with their local WIBs and/or serve as WIB members. 2. LTC providers should be encouraged to use the WIBs to list job openings with the Virginia Employment Commission and with the area employment services
	C. Increase retention of direct support professionals	1. Examine ways the Virginia Department of Health (who licenses nursing facilities), Virginia's Quality Improvement Organizations (QIOs), and nursing facilities can work together to implement proven organizational change models, such as the Eden Alternative™ and the Wellspring Innovative Solutions© in the majority of facilities 2. Examine ways to ensure there is continuous ongoing training of the direct support professionals such as peer mentoring, career ladders, and a middle college concept 3. Determine various methods to provide health insurance to direct support professionals 4. Provide scholarships and loan repayment programs to direct support professionals
	D. Align regulation to increase recruitment and retention of the direct support professional	1. Follow the Joint Commission on Healthcare study on Barrier Crimes and make appropriate recommendations based on its findings for the Governor's consideration and review. 2. Standardize the training requirements for direct support professionals (i.e. eliminate the differences that exist depending on which setting the worker goes into) 3. Standardize wages for direct support professionals who are

	workforce	currently paid differently based on their training levels despite all providing the same basic functions
2. Accurately measure the progress towards increasing supply and decreasing demand	A. On annual basis develop and/or assign accountability for collection and evaluation of workforce metrics to guide policy decisions	1. Fund ongoing analysis of currently available health professions workforce data 2. Implement a systems infrastructure that assures data collection and analysis on the supply & demand of healthcare workers 3. Provide annual direct support professional workforce supply and demand reports to the Governor and General Assembly 4. Facilitate centralized data collection and analysis to improve the quality and quantity of healthcare workforce data through DHP 5. Assign accountability for data review and workforce strategy development to DHP, VDH, and OSHHR
	B. Lay the groundwork to continue increasing pipeline for direct support professionals	1. Disseminate information about career ladder including moving from a direct support professional to LPN to RN as well as moving from the nursing facility setting to other settings 2. Create healthcare worker intake programs for immigrant and low-income communities 3. Revamp high school programs to include career/technical courses focused on healthcare while in high school allowing for a completion of a CNA at graduation 4. Recommend providers and training programs teach ESL skills and GED as part of their CNA curricula 5. Develop public-private partnerships and marketing campaigns to increase awareness about the role of direct support professionals, recruit more direct support professionals, disseminate best practices, incorporate direct support professionals into multi-disciplinary teams, etc. 6. Award tax credits to direct support professionals in order to provide a financial incentive
3. Manage demand for direct support professionals	A. Incent providers for excellence	1. Modify reimbursement methodologies to the direct reimbursement of nursing care so that revenues can be used to improve staffing levels 2. Create a Virginia Nurse Support Recognition Program - Governor's Nurse Support Award
	B. Improve workflow through appropriate technology	1. Create a competitive grant process for improving work environment and/or patient safety 2. Develop incentives for long-term care providers to use more sophisticated technology that will improve the work environment for the direct support professional workforce

APPENDIX J: STATE NURSING HOME PAY-FOR-PERFORMANCE PROGRAMS

Early Approaches	
Illinois	Began early 1980's and provided reimbursement incentives for the achievement of six quality measures. Relative improvement from one to six stars provided a $100,000 per year incentive. Bonuses in 1989 summed to $20 million. Validity of measures and link between the measures and quality outcomes not firmly established. Some incentives may have rewarded a structural measure that was not linked to improved quality. Program ended after the passage of OBRA of 1987.
Colorado	A $3 million program in FY 96-97, but was repealed in 2002 when state Medicaid allowable costs increased.
Texas	The Performance Based Add-On program in FY 2001-2002 used quality measures developed by the Center for Health Systems Research and Analysis (CHSRA) and survey deficiencies to assess quality performance.
Financial Incentives	
Kansas	The "PEAK" program initiated in 2002 continues to support the development of non-traditional models of care. Financial incentives are provided for achievements in direct care staffing, direct care turnover, staff retention, operating costs, total and Medicaid occupancy, and certification survey results. Incentives ranged from $1 to $3 per resident day.
Iowa	In effect since 2002, the Accountability Measures Incentive program continues to award points in ten areas. In FY 2005, 87% of participating facilities received enhanced payments. Providers are generally satisfied with the totality of the measures, but question whether the measures alone provide sufficient incentives.
Minnesota	In effect since October 2006, the MN Value-Based Reimbursement program uses 23 quality measures recommend from a variety of sources (UMN research team, CMS Nursing Home Compare, CHSRA, Brown University, and Abt Associates), in addition to weighted staffing measures and survey deficiencies. Facilities are rated on 8 components; efficiency and quality are rewarded up to 5% of the operating payment rate.
Georgia	In effect since 2003, the Georgia Nursing Home Incentive Model or Georgia Quality Initiative is a statewide, public-private partnership to support quality improvement efforts in nursing facilities. Eight criteria are used to determine the level of incentive reimbursement to individual providers. Both "My InnerView" and CMS data are used.
Oklahoma	Focus on Excellence program will be initiated in 2007 and is comprised of three main elements: (1) quality rating system leading to a tiered reimbursement, (2) consumer outreach through a public scorecard designed to provide nursing facility quality ratings, and (3) evidenced-based management data and tools for provider performance improvement. "My InnerView" is contracted to design/manage the reimbursement program.
Non-Financial Incentives	
North Carolina	In effect since January 2007, the NC New Organizational Vision Award (NC-NOVA) uses a special licensure program for nursing homes, home care agencies, and adult care homes that demonstrate a positive workplace culture in order to improve the recruitment and retention of direct care workers. Currently, the reward is non-financial; however, future plans include using the special designation as a basis for awarding Medicaid reimbursement differentials or Medicaid wage pass-throughs.
Vermont	In effect since 2005, the Gold Star program recognizes facilities that institute evidence-based practices to improve recruitment and retention of direct care staff. Those designated with a "star" are eligible to win one of five annual quality awards of $25,000.
Wisonconsin	In effect in 2007, The Nursing Home Recognition for Performance Quality Initiative (R4P) will be using a quality index scorecard based on a 100-point system. The 2007 data will be used as the baseline year. The weighted scoring emphasizes adequate & consistent staffing, as well as stable leadership.
National Demonstration	
CMS Nursing	The voluntary demonstration is proposed to include 50 homes per state in 4 to 5 states in

Home Quality Based Demonstration for Medicare	the intervention group and a similar sized and stratified group for the control. Abt Associates have developed an extensive set of recommendations for the proposed demonstration. Medicare savings will be reinvested into the incentive payment pool.

APPENDIX K: RELATIVE MIX OF OUTCOME MEASURES

	MDS-Based Measures	Staffing Measures[1]	Quality of Life Measures[2]	Survey Deficiencies	Other
CMS Proposed Medicare Demonstration (Abt Associates)	20%	30%	0%	20%	30% (Reductions in potentially avoidable hospitalizations)
Iowa (eff. 2002)	0%	25%	16%	25%	33% (efficiency measures)
Kansas (eff. 2005)	0%	44%	0%	22%	33% (efficiency measures)
Minnesota (Original proposal never went into effect)	14%	63%	13%	10%	0%
Minnesota (Revised proposal eff. October 1, 2006)	40%	50%	0%	10%	0%
Texas (2001-2002)	50%	0%	0%	50%	0%
Vermont (weights unavailable)		√	√	√	
Wisconsin (eff. 2007)	0%	70%	0%	20%	10% (Private Rooms)
Oklahoma (eff. 2007)	10% (Alternative Quality Indicators)	35%	15%	15%	25% (Medicaid utilization, disaster preparedness, trade organization membership)

[1]Staffing Measures include resident to staff ratios, staff turnover and retention, and employee satisfaction
[2]Quality of Life Measures include resident satisfaction, resident interviews, etc.

Compiled descriptions provided by DMAS based on March 2007 data

APPENDIX L: MEASURE TYPES USED IN NURSING HOME P4P PAYMENT SYSTEMS

Resident Outcomes (MDS Quality Measures)
General Description and Rationale for Inclusion: During their stay in a nursing home, residents are assessed by the facility staff. This assessment is called a Minimum Data Set (MDS) Assessment and is performed at admission, quarterly, annually and whenever the resident experiences a significant change in status. This extensive assessment includes many items such as: diagnosis; the ability to do certain tasks such as get in and out of bed, walking, eating, bathing, toileting, et,; clinical conditions such as the presence of sores, wounds or cuts on the body; use of certain types of medications; dehydration; mental functioning; and certain cares and treatments provided to the resident.

Pros	Cons	Comments and Issues
• These are direct outcome measures. • MDS data is readily available. • Performance is in control of provider.	• According to studies, only a small number are statistically valid and reliable. • Studies reveal contradictory findings with regard to the validity of some currently available MDS QMs. • Self-reported data where inconsistencies or misinterpretation of measures could exist. • DMAS does not currently extract all the MDS variables that might be used in calculating quality measures.	Selecting MDS-based Quality Measures CMS currently posts 19 MDS-based quality measures (QMs) on its Nursing Home Compare web site available to the public (14 long-stay measures and 5 short stay measures). When Abt reviewed these quality measures for the Medicare NH P4P demonstration it recommended only 5 out of the 14 long-stay measures from the CMS Nursing Home Compare and 3 short-stay QMs proposed by another CMS contractor that met the following criteria: ▪ Are valid and reliable. ▪ Are under the nursing home's control. ▪ Have good statistical performance. ▪ Reflect important societal values. Abt recommended not using 8 long-stay measures and 4 short-stay measures on Nursing Home Compare for various reasons. Abt did not include pain with the other recommended MDS-based QMs because of concerns about differences across nursing homes in how they assess pain. Abt, however, has recommended further consideration of a long-stay and short-stay QM for pain. In contrast to the Abt recommended approach for the Medicare NH P4P demonstration (a few valid and reliable MDS items), Texas and Minnesota use a large number of MDS QMs. The cumulative results could still be valid and reliable. Texas Performance Based Add-On Program (2001 – 2002) used 24 QMs developed by the Center for Health Systems Research and Analysis (CHSRA) and combined above average scores with below average scores. Minnesota Value-Based Reimbursement, which was implemented 10-1-06, uses 23 QMs recommended from a variety of sources (UMN research team, CMS Nursing Home Compare, CHSRA, Brown University, Abt Associates). *Selecting Change or Prevalence Measures* Some QMs measure change while others measure prevalence. *Measuring Quality for Long-stay and/or Short-stay Residents* Since Medicaid recipients are primarily long-stay, it may not add value to develop criteria for short-stay residents and would complicate the calculation. Many Medicaid nursing homes are not dual-certified for Medicare residents. But some Medicaid nursing homes, particularly hospital-based nursing homes, primarily serve short-stay residents. Measurement Issues Calculating many of the potential QMs, especially the most sophisticated ones are not straightforward. Many of them measure differences between recent quarters. Others exclude some assessments or risk-adjusted. DMAS does not currently extract all the MDS data needed to calculate the QMs as currently specified. Calculating them may be difficult to do in house. DMAS may be able to obtain them from CMS or some other source on a timely basis. Not clear whether MDS scores are measured once (at the end of the performance period) or multiple times (quarterly) and averaged.

Staffing Levels

General Description and Rationale for Inclusion: There is strong evidence that low nurse staffing levels seriously compromise quality of care. Based on previous studies, higher staffing levels in nursing homes have been found to be associated with fewer hospitalizations, fewer infections, fewer pressure ulcers, less skin trauma, less weight loss, decreased resistance to care, and higher levels improved functional status. Several Pay-For-Performance programs (Iowa, Kansas, and Minnesota) use staffing-related performance measures. The two most frequently used are total nursing hours per resident day and turnover percentage for nursing staff.

Pros	Cons	Comments and Issues
Nursing hours • CMS reported a relationship between staffing (particularly RNs) and a variety of outcomes, including: – lower death rates, – higher rates of discharges to home, – improved functional outcomes, – fewer pressure ulcers, – fewer urinary tract infections, – lower urinary catheter use, and – less antibiotic use. ▪ Nurse staffing data available on annual nursing home wage survey and cost report.	1. Shortage of RNs, LPN, and CNAs currently exist. Problem is aggravated if shortage is unevenly distributed. 2. Data is self-reported and not currently audited. 3. Variations between facilities in the needs of residents (can adjust for). 4. There are very large differences in RN staffing levels for the two nursing home types, hospital-based and free-standing. 5. A small percentage of nursing facilities do not respond to annual survey. 6. Turnover or retention data not currently collected. 7. Many people feel that turnover has a major negative impact on quality but research has not definitely demonstrated a relationship between nursing home staff turnover and quality of care (Abt Associates).	<u>Selecting Staffing Measures</u> All but one program has used multiple staffing criteria. Abt recommends using RN hours per resident day, total nursing hours per resident day, and turnover percentage for nursing staff for the Medicare NH P4P demonstration. RN staffing levels may not be as important for Medicaid population as Medicare population. Minnesota Value-Based Reimbursement program includes weighted direct care staff hours per resident day (Minnesota also counts non-nursing direct care staff), direct care staff turnover, direct care staff retention, and use of temporary/pool staff. Iowa awards one or two points (out of a total of 12 possible) based on total nursing hours per resident day. Kansas uses direct care staffing, direct care staff turnover, staff retention. Texas Performance Based Add-On Program (2001 – 2002) did not use any staffing measures due to a lack of current and audited staffing information at the time but Texas has an alternative voluntary Direct Care Enhancement Program that provides additional funds for homes whose staffing levels exceed the state average. <u>Measurement Issues</u> DMAS currently collects staffing on a calendar year basis or a provider FYbasis, which would be inconsistent with a program based on the state fiscal year. When combining different staff types, DMAS might consider weighting the different skill levels. Minnesota, for example, gives a weight of 1 for CNAs and higher weights to higher qualified staff. Abt recommends a lower weight for agency staff. Most programs case mix adjust the staffing results for each nursing home. DMAS could do that using nursing facility case mix scores. CMS found when examining ratios of nurses to residents that there was a pattern of incremental benefits of increased staffing until a threshold was reached at which point there were no further significant benefits with respect to quality when additional staff were utilized. May need to consider separate scoring if hospital based nursing homes are included. Turnover and/or retention data could be added to the annual nursing home wage survey. DMAS may need to begin to audit this. One way to do this would be to make sure that data reported on the wage survey is consistent with data reported on the cost report. It would mean asking NFs who do not have a 12/31 FYE to report the wage survey information in two periods.

Survey Deficiencies

General Description and Rationale for Inclusion: All nursing homes that participate in Medicare or Medicaid must have a certification survey on a regular basis (on average once every 12 months) to ensure that they meet certain federal requirements. There are a total of 190 different requirements (categorized into 17 major areas e.g., nursing, physical environment, kitchen/food service, quality of care, quality of life, resident behavior; nursing home practices, etc.). The surveys provide a snapshot of a nursing home's quality of care at the time of the survey. When a nursing home fails to meet a specific requirement, the nursing home receives a letter deficiency based on scope and severity (see table below). Survey deficiency data is recorded in the CMS Online Survey Certification and Reporting (OSCAR) system. Survey deficiencies may be used in two ways:

1. As a screening measure that would disqualify any nursing home that, in the evaluation period, received a citation for substandard quality of care. This screening criterion would help to ensure that homes with otherwise good performance would not receive any performance payment as a result of the serious quality of care issues identified by surveyors.
2. As part of a nursing home's performance scores.

<table>
<tr><th>Pros</th><th>Cons</th><th>Comments and Issues</th></tr>
<tr>
<td>
• CMS' survey represents the minimum federal requirements. These surveys evaluate the quality of care and services provided by nursing homes, as well as the nursing home's building, equipment, staffing, policies, procedures and finances.

• Survey results should be easy to access.

• Several other rating systems have been developed to rank nursing home performance based on survey deficiencies allowing for choices of this measurement type (American Healthcare Association, 2003).

• Used in all rating systems.
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• Scoring may be inconsistent among surveyors who assign a scope and severity rating for each deficiency.

• Timing and posting of survey deficiency data results may not correlate with evaluation period.

• Focus on the negative.
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<td>
<u>Selecting Survey Deficiency Measures</u>
Abt recommends excluding any nursing home with substandard quality of care. According to Abt, shaded cells denote a deficiency level that constitute substandard quality of care if it involves a requirement related to resident behavior and nursing home practices, quality of life or quality of care. Nationally, about 25% of nursing homes have substandard quality of care using this standard. To measure performance, Abt recommends measuring all deficiencies using an escalating weighted scale (no points for A-C; 2-6 points for D-F, 10-30 for G-I; and 50-150 for J-L).

<table>
<tr><th rowspan="2">Severity</th><th colspan="3">Scope</th></tr>
<tr><th>Isolated</th><th>Pattern</th><th>Widespread</th></tr>
<tr><td>Immediate jeopardy to resident harm or safety</td><td>J</td><td>K</td><td>L</td></tr>
<tr><td>Actual harm that is not immediate jeopardy</td><td>G</td><td>H</td><td>I</td></tr>
<tr><td>No actual harm but potential for more than minimal harm</td><td>D</td><td>E</td><td>F</td></tr>
<tr><td>No actual harm with potential for only minimal harm</td><td>A</td><td>B</td><td>C</td></tr>
</table>

Minnesota scores deficiencies on seventeen requirements considered directly important to quality care (physical restraints, chemical restraints, abuse, dignity, choice of activities and schedules, ADLs, maintain or improve physical abilities, pressure sores, catheters, bladder treatment, NG tubes, nutrition, hydration, drug prescribing, antipsychotic drug use, medication errors, sufficient staff). Minnesota determined two levels of compliance: all deficiencies below level E and 5 and all deficiencies below level H.

Iowa determined two levels of compliance: "deficiency free" and "regulatory compliance" (no on-site revisit required). Kansas determined two levels of compliance: "deficiency free" and no substandard care deficiencies with no more than five total deficiencies. Texas determined three levels of regulatory compliance: deficiency-free, substantial compliance (no deficiency greater than C), minimum acceptable level of compliance (no deficiency greater than F). Texas also disqualified a nursing home with substandard quality of care (see Abt above).

<u>Measurement Issues</u>
Every nursing home may not have a survey during the 12 month performance period. Can use the most recent survey, but at some
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		point, the available surveys may be too old. May need to work with VDH/CMS. Some NFs will have additional complaint survey(s). Most programs also use complaint survey results since the last regular survey. Assume that DMAS would have access to survey deficiency data. Need to explore with VDH/CMS. If calculating an "average," must give point values to deficiencies. May want to weight survey deficiencies.

Avoidable Hospitalizations

General Description and Rationale for Inclusion: Nursing home residents are most commonly hospitalized for infections, falls and fractures, and cardiovascular events. Pneumonia, a common nursing home acquired infection, is the leading cause of morbidity, death, and hospitalization in nursing home residents. Studies suggest that careful management of ambulatory care-sensitive conditions (e.g., congestive heart failure, chronic obstructive pulmonary disease, diabetes mellitus, urinary tract infections and pneumonia) may reduce hospitalizations and that as many as 36 percent of emergency department transfers and 40 percent of hospital admissions were inappropriate. Studies also suggest that for some conditions there is no significant difference in outcomes between residents treated in nursing homes and those hospitalized. Furthermore, outcomes for nursing home residents transferred to the hospital may be worse than those who remain in the nursing home.

Pros	Cons	Comments and Issues
• Uses hospital claims data • Avoiding hospitalization is a positive benefit to NH residents.	• Complex calculation matching hospitalizations to NH stays. • Nursing homes may avoid necessary hospitalizations. • Nursing homes may avoid sicker patients unless there is a risk adjustment.	<u>Selecting Measures</u> Abt's recommendation for this measurement is based on the premise that the CMS demonstration is to be financed based on the reduction in certain Medicare expenditures achieved across participating homes in each state. Abt notes that the most direct method by which nursing homes can control Medicare expenditures is by reducing hospitalizations. Significantly reducing hospitalization may not save as much money for Medicaid as Medicare because Medicare is the primary payer for hospital care for dual eligible recipients. No other NH P4P plan includes similar criteria. Abt recommends using the list of ambulatory-care sensitive conditions that was developed by the Agency for Healthcare Quality and Research (AHRQ). The AHRQ list of ambulatory-care sensitive conditions was initially developed for community residents and not developed specifically for the nursing home population. These are hospitalizations that stem from medical conditions thought to be largely avoidable and/or manageable (e.g., dehydration, diabetes, congestive heart failure, COPD, urinary tract infection) if they are treated in a timely fashion with access to outpatient physician and other medical support services. Abt recommends separate measures for short-stay (Medicare covered days) and long-stay (Medicaid covered days), but a Medicaid pay-for-performance plan may focus only on long-stay. <u>Measurement Issues</u> Need to case mix adjust. Do not give points for very low hospitalization so that nursing homes do not avoid necessary hospitalizations. May not be able to calculate this in house. Nursing home may have too few residents for the hospitalization performance measure to be calculated.

Resident/Family Quality of Life Surveys

General Description and Rationale for Inclusion: Many nursing homes utilize resident, family, and employee satisfactions survey tools in their efforts to improve quality. Nursing home satisfaction represents a multidimensional collection of issues related to various aspects and experiences of the particular group responding (i.e., resident or family). There are a number of resident and family surveys in use (or under development) having been constructed for a variety of purposes – for nursing home selection, for quality improvement initiatives, for public reporting and as a component to adjust reimbursement rates (e.g., provide care-related payment incentives). A number of these instruments have undergone extensive development and testing. About 120 Virginia nursing homes use "My Inner View," a commercial survey instrument, as a quality improvement tool.

Pros	Cons	Comments and Issues
• Includes the resident and the resident's family in a quality-based payment system.	• There is no currently available data source in Virginia. • Difficult to audit. • Resident satisfaction measures process. There is little evidence of a link between process measures and resident outcomes (Abt Associates). • Resident surveys are already used by nursing home surveyors to identify possible deficiencies.	<u>Selecting Measurement Criteria</u> Abt recommends consideration of two possible performance measures: nursing home use of resident assessment of care surveys and/or a performance measures derived from the Nursing Home CAHPS (Consumer Assessment of Health Plans Survey) survey once development and testing of this instrument is completed. Domains include global ratings on staff care and nursing home, getting needed care, getting care quickly, staff helpfulness/courtesy and staff communication. Minnesota Value-Based Reimbursement program uses a resident satisfaction and quality of life interview on a variety of topics that include comfort, environmental adaptations, privacy, dignity, spiritual well-being, meaningful activity, food enjoyment, autonomy, individuality, security, relationships and mood. Trained interviewers employed by an independent contractor of the state interview a statistical sample of residents in each facility. Iowa: Iowa uses a measure of resident satisfaction as an optional measure. Homes must be at or above the 50th percentile of resident satisfaction based on a Resident Opinion Survey (31 items/questions about staff, quality of life, housekeeping, and activities). Homes distribute the survey to their residents for completion and the surveys are returned to an independent entity that compiles the survey results and completes a state form. <u>Measurement Issues</u> May be difficult to score nursing home use of resident assessment of care surveys.

Compiled descriptions provided by DMAS

APPENDIX M: INVENTORY OF INITIATIVES/PROGRAMS ADDRESSING INFANT MORTALITY IN VIRGINIA

Name	Purpose	Locality	Target Population	Eligibility	Funding
Assisted Reproductive Techniques Provider Education	Increase the awareness of the rise in LBW and VLBW births in the Northern Virginia Perinatal Council Region	Northern Virginia	Assisted Reproductive Techniques providers	Resident of geographic region	March of Dimes grant; administered by Northern Virginia Perinatal Council
Baby Basics Southwest Virginia (VDH)	Provide a comprehensive low literacy and culturally sensitive guide to pregnancy, promoting healthier pregnancy outcomes and healthier futures for the babies of the region	Tazewell, Wise, Smyth, and Washington Counties	Pregnant women at their first prenatal visit	Receiving care with local OB/GYNs in Abingdon, Richland, and Big Stone Gap	Grants: CJ Foundation for SIDS, Children's Miracle Network, Johnston Memorial Hospital, Clinch Valley Medical Center, private donations
BabyCare	To improve birth outcomes for high risk mothers and infants	20 health districts provide services	High risk pregnant mothers and infants up to age 2 years	Fee for Service Medicaid or FAMIS eligible Identified risk by screen	Medicaid, state, federal
Back to Sleep and Hidden Hazards of Adult Beds for Infants (CPSC)	Reduce the number of deaths due to SIDS and other Sudden Unexplained Infant Deaths	Central Commonwealth Perinatal Council	Parents, families and caregivers	Resident of geographic region	Title V, Hayes Hitzeman Foundation, The Hodges Partnership Va. Hosp. Laundry
Beds & Britches, Etc.	Increase first trimester prenatal care	South Central Perinatal Council	Teens and women	Low income residents of geographic region	Grants: Title V, Children's Miracle Network, Ronald McDonald House Charities
Breastfeeding: A Continuing Education Program for Healthcare Providers	Increase Healthcare Providers (HCP) breastfeeding knowledge and skills to aid women and their infants	8 hospitals in the Blue Ridge Perinatal Council region and health departments	Nursing staff in hospitals and health department staff	HCPs in the geographic region	March of Dimes grant, BRPC excess revenue, Title V/ with matching funds from all participating hospitals
Childbirth Education	Provide childbirth education classes to expectant parents	Alleghany Highlands	Expectant parents	Resident of geographic region	State and Federal Title V

Name	Purpose	Locality	Target	Eligibility	Funding

			Population		
CHIP of Virginia	To increase access to healthcare providers	11 sites	Pregnant women or families with children age 6 or younger	Up to 200% poverty	State (GF, TANF)/local government; private and contracts
Comenzado Bien	Increase Spanish-speaking women's awareness of preterm labor. Provide culturally-competent teaching and support	Northern Virginia	Spanish-speaking women	Resident of geographic region	Title V, March of Dimes grant, JWCL donation
Community Voice: Taking it to the People	Decrease racial disparities in infant mortality	Lynchburg	African American women of childbearing age	Resident of geographic region	Grant from March of Dimes, South Central Perinatal Council
Community Voices	Increase public awareness of African-American infant mortality and morbidity. Increase public knowledge of perinatal health	City of Martinsville	African-Americans	Resident of geographic region	Grants: March of Dimes and For the Children
Comprehensive Sickle Cell Services	Provide parent education and support to families whose child is diagnosed with an inherited disorder	Statewide	Parents of newborns identified with Sickle Cell disorder	None	State
Early Head Start	To promote social and cognitive development for school readiness in economically disadvantaged communities	11 EHS sites	Economically disadvantaged pregnant women and infants up to age 3 years	Medicaid eligible	Federal, local
Governor's New Parent Kit 2007	To educate new parents about early child development and connect them with existing state resources	Statewide	All new parents	Resident of the Commonwealth	State – Partnership between VDH and DSS
Healthy Families	To promote healthy family development and child development	90 cities and counties	First time parents (some sites first time pregnant women as well) up to the child's 5th birthday	First time pregnant women screened at risk	State, local government, federal, private and local

Name	Purpose	Locality	Target	Eligibility	Funding

			Population		
Infant Safety Campaign	Promote community awareness of the dangers of infant suffocation and safe sleeping environment	Roanoke City, Roanoke County, and Salem	720 obstetric clinic patients in the Roanoke metropolitan area	Resident of geographic region	Grant from the VDH- Injury Prevention Program
Inova Perinatal Concerns Program (IPCP)	Support families expecting a child with a fetal anomaly by removing the burden of the unknown and guide them to resources	Northern Virginia	Pregnant women and their families	Resident of geographic region	Aetna Foundation grant, Inova Fairfax Hospital, Booz Allen Hamilton donation, Families donations, Yards for Youth program fundraising activities
Low-Income Safety Seat Distribution Program	Reduce deaths of infants and toddlers, secondary to automobile accidents	Statewide	Families with children through 5 years	Medicaid and FAMIS eligible families	State Federal
Operation Preemie	Educate healthcare providers, pregnant women and the general public on preterm labor	Northern Virginia	HCPs, pregnant women, community	Resident of geographic region	Title V, Bristol Meyers Squibb, Johnson and Johnson, March of Dimes
Project LINK	To promote healthy pregnancies	37 cities and counties	Pregnant and parenting teens and women at risk for substance use	History of substance use or current risk	Federal, local
Regional Perinatal Councils	Improve outcomes of perinatal health, reduce infant mortality and morbidity using initiatives implemented by the consortium	Statewide (seven regions)	Women and infants	None	Title V
Resource Mothers	To improve birth outcomes for teen parents and their infants	88 cities and counties	Pregnant and parenting teens and their infants	Teen Ages 10-19 who are pregnant	
Richmond City Healthy Start	Reduce the rate of infant mortality and improve perinatal outcomes in high-risk communities	Richmond City	Pregnant teens, women, high risk infants	Residents of Richmond City	

Name	Purpose	Locality	Target	Eligibility	Funding

			Population		
Virginia Healthy Start/Loving Steps	Reduce the rate of infant mortality and improve perinatal outcomes in high-risk communities	Norfolk, Petersburg, and Westmoreland	Pregnant teens, women, high risk infants	Residents of Norfolk, Petersburg and Westmoreland	Federal HRSA grant
Virginia Newborn Screening	Reduce mortality and/or morbidity associated with genetic and/or metabolic disorders	Statewide	Newborns	None	Enterprise Fund
Wake Up Call	Improve the communities awareness of SIDS	Buchanan, Dickerson, Grayson, Lee, Russell, Scott, Smyth, Tazewell, Washington and Wise counties, also cities of Bristol and Norton	New and expectant parents and families, childcare providers and healthcare providers	Resident of geographic region	Grant from CJ Foundation for SIDS
Women, Infants and Children (WIC)	Prevent prematurity and promote healthy growth of infants	Statewide	Pregnant women and infants	Women and children below 180% of poverty	Federal (USDA)
Women's Health and Perinatal Health	Increase the number of pregnant women who receive early and adequate prenatal care by providing perinatal health related education and training	Virginia Beach	Women working at the Lillian Vernon Corporation Distribution Center	Resident of geographic region	State, Federal – Title V

APPENDIX N: LISTING OF ALL INFANT MORTALITY RECOMMENDATIONS

Goal	Objectives	Strategies
1. Assure that all women receive services that will enable them to enter pregnancy in optimal health and remain in optimal health throughout and after pregnancy	A. Increase funding and services for preconception, interconception, pregnancy, and postpartum care	1. Encourage the use of proven effective approaches such as community-based home visiting programs A. Revise and promote the use of existing BabyCare program for case management of high-risk pregnancies B. Provide additional funding to effective home visiting programs that meet those criteria established for publicly funded home visiting programs (such as Healthy Start, Healthy Families, CHIP of VA, and Resource Mothers) 2. Expand and enhance FAMIS coverage A. Expand for women up to 250% Federal Poverty Level B. Provide services in FAMIS during pregnancy and up to one year postpartum C. Include oral health coverage in Medicaid/FAMIS for pregnant women 3. Expand the Family Planning Waiver to 200% of Federal Poverty Level 4. Create presumptive eligibility for pregnant women in Medicaid 5. Increase Medicaid reimbursement for maternity and pediatric providers 6. Provide Medicaid reimbursement for registered dietitians 7. Develop fiscal incentives for screening and health promotion 8. Develop fiscal incentives for risk management, particularly in managed care settings
	B. As a part of primary care visits, provide risk assessment and educational and health promotion counseling	1. Implement “universal risk screen” for pregnant women 2. Promote a dental visit before conception for evaluation and treatment of oral diseases, especially periodontal disease
	C. Develop and increase the workforce providing maternity care	1. Establish scholarship/loan repayment program for medical and nursing students electing to pursue residency training and/or nurse midwifery in underserved areas 2. Improve cultural competency in physician-patient relationship 3. Encourage ethnic minorities to practice in the field of obstetrics 4. Provide CME based training opportunities on cultural competency 5. Provide incentives for family practitioners to practice maternity care in underserved areas by creating malpractice risk pools
2. Reduce risks indicated by a previous adverse outcome through interventions during the interconception period	A. Promote interventions for identified risks	1. Develop case management services for women with these underlying conditions to support primary care providers in their practices. Provide women with primary medical home during the interconception period. A. Identify at risk postpartum women and proactively enroll in case management services through insurers B. Reimburse pediatric providers for maternal depression risk screening and referral

	B. Use the interconception period to provide additional intensive interventions to women who have had a previous pregnancy which ended in an adverse outcome	1. Monitor the percentage of women who complete postpartum visits and use these data to identify communities at risk and opportunities to improve provider follow-up 2. Develop, evaluate, and replicate intensive evidence-based interconception care and care coordination models for women at high social and medical risk 3. Increase the number of reimburseable postpartum visits to promote interconception health 4. Develop preconception health improvement projects with funds from the Title V Maternal Child Health Block Grant, Prevention Block Grant, and similar public health programs 5. Promote the use of supplemental progesterone for women who had already delivered a preterm baby
	A. Increase public and private health insurance among women with low incomes	1. Improve the design of family planning waivers to offer interconception risk assessment, counseling, and interventions along with family planning services 2. Increase health coverage by using federal options and waivers under public and private health insurance systems and S-CHIP 3. Increase access to health services through policies and reimbursement levels for public and private health insurance systems to include a full range of clinicians that care for women
3. Reduce the disparities in adverse pregnancy outcomes	B. Increase the evidence base and promote the use of evidence to improve preconception health	1. Encourage and support evaluation of model programs and projects
	C. Maximize public health surveillance and related research mechanisms to monitor preconception health	1. Expand data systems and survey to monitor individual experience related to preconception care A. Increase funding for existing surveillance functions including FIMR, PRAMS, Maternal and Child Mortality Review, and VaCARES 2. Designate perinatal underserved areas to encourage community planning and enhancement of healthcare delivery system for pregnant women and their infants A. Establish a statewide safety net of services through local health departments and community health centers so that all areas of the state have a core set of services available
4. Improve the health of women during pregnancy to reduce the risk for poor birth outcomes.	A. Decrease the negative impact of psychosocial issues on pregnancy outcome.	1. Encourage providers to screen for psychosocial issues such as domestic violence, substance abuse, stress, and perinatal depression. A. Provide financial incentives for providers to screen for psychosocial issues through insurance reimbursement. 2. Designate pregnant and postpartum women as priority populations for mental health services through publicly supported programs.
	B. Increase the number of women that gain a healthy weight during pregnancy.	1. Provide additional funding to VDH to support CHAMPION infrastructure costs and grants to community groups. 2. Promote and increase the participation eligible women in WIC.

5. Assure that all pregnancies are wanted and planned.	A. Reduce unintended pregnancy.	1. Financially support local health districts to provide expanded family planning services. 2. Increase the variety of contraceptives available through local health departments. 3. Increase state funding to the voluntary sterilization program.
6. Assure that all newborns and infants receive services to reach and maintain optimal health status.	A. Enhance workforce capacity for pediatric health services.	1. Provide training for all providers on prenatal depression screening and domestic violence/abuse screening. 2. Establish adequate referral resources for clients identified through screening as needing help or treatment. 3. Promote the medical home concept for all providers of pediatric care.
	B. Establish fiscal policies and practices that support maximizing the workforce capacity.	1. Enhance reimbursement to pediatric providers for performing: perinatal depression screening, comprehensive developmental screening; anticipatory guidance, and care coordination in a medical home. 2. Create incentives for Medicaid managed care organizations to improve their performance in perinatal depression screening, comprehensive developmental screening; anticipatory guidance and care coordination.
	C. Promote development of community linkages and systems integration.	1. Expand WIC services to locations outside local health departments. 2. Create pilot projects that identify high-risk neonates and assure long term follow-up and linkage to Part C. 3. Provide financial incentives to providers that work with established home visiting programs that meet state criteria and demonstrate healthy child outcomes.
	D. Prevent injury related hospitalizations or death in infants.	1. Support the VDH safety seat program. 2. Educate parents and providers regarding SIDS and safe sleep environment. 3. Educate parents regarding poisons and providing a safe home environment. 4. Strengthen the prevention interventions on child abuse through provider and public education.

APPENDIX O: LISTING OF ALL OBESITY RECOMMENDATIONS

Category	Goal	Strategies
1. School System	A. Establish consistent nutritional standards throughout the school environment	1. Develop additional incentives to increase school participation in the Governor's Nutrition and Physical Activity Scorecard program A. Raise visibility and recognition through partnerships in the community B. Ask Governor to send letter to school principals to encourage participation and to commend those who receive awards C. Continue to strengthen and improve program such as developing a school system/division award D. Work with the Advertising Center @ VCU to develop a public campaign E. Governor should continue to visit and recognize schools and school systems 2. Revisit standards for competitive foods and update state regulations as needed 3. Recommend all food purchases be made by nutrition programs in the schools 4. Bring under the State's management the summer feeding programs 5. Encourage schools to follow Board of Education and Board of Health recommendations regardless of ability to meet Governor's scorecard standards 6. Create a bulk purchasing model for healthy foods initially targeting school divisions with the intent to expand to all state agencies
	B. Increase physical activity in the school system	1. Establish state performance benchmarks/goals for physical fitness and BMI through the VA Wellness Related Fitness Test (VWRF) A. Require reporting of this data by all school divisions to DOE 2. Recommend standards of accreditation be reviewed to define recess as promoting physical activity 3. Recommend an increase in the number of times per week and amount of time spent in physical education increase through a phased approach 4. Examine feasibility of the use of a data management system to create individualized report cards for parents to see their child's fitness levels. Network this with the local health departments
	C. Work to advance current processes within the school system	1. Develop recommendations for increasing the number of schools teaching and evaluating health and physical education 2. Emphasize and support the school health advisory boards role in preventing childhood overweight and obesity 3. Define models for effective collaboration between local health departments and school divisions and replicate across the state 4. Strengthen partnership between VDH and DOE to develop lesson plans and instructional tools for nutrition and physical education 5. Develop an SOL test for health education for elementary and secondary levels 6. Conduct focus groups with middle and high school students to determine what can and should be done 7. Send a memo to the Board of Education from the Health Reform Commission with all recommendations concerning schools

	D. Increase funding in school system	1. Apply for CDC grant to implement coordinated school health programs 2. Implement CDC's Youth Behavioral Risk Survey to receive additional funding 3. Provide incentives for local School Health Advisory Boards to strive towards using the CDC's School Health Index to identify strengths and weaknesses of their health promotion, policies, and practices 4. Increase funding for the school breakfast and school lunch programs 5. Develop a matching grant program to build and expand upon healthy initiatives taking place in the schools
2. Community	A. Finalize the development of the VDH CHAMPION statewide obesity prevention plan and proceed with implementation	1. Establish Governor's statewide CHAMPION advisory committee 2. Identify proven, evidence-based, cost effective programs that can be replicated in communities across the Commonwealth 3. Provide training, technical support, and seed money to community groups implementing programs contained in the statewide plan 4. Provide additional funding to VDH to support CHAMPION infrastructure costs and grants to community groups 5. Examine feasibility of proposed VA Youth Overweight Collaborative with the VA Chapter of the American Academy of Pediatrics, Academic Medical Centers, and other partners
	B. Increase funding for health and nutrition initiatives	1. Ensure reimbursement to medical care providers for addressing prevention and medical treatment of obesity 2. Provide Medicaid reimbursement for registered dietitians 3. Create a Healthy Rewards program for Medicaid to reward those enrollees who meet their health goals with credits that can be used to cover medical and pharmaceutical co-pays 4. Provide reimbursement for dietitians through the state employee health plan
	C. Improve nutritional offerings to the general public and state facilities	1. Study access to healthy foods in all parts of the state 2. Create more informative nutrition guidelines in grocery stores 3. Require restaurants, including fast food chains, to show nutritional value in menus and provide health warnings 4. Work with restaurants to provide more healthy menu options 5. Post nutritional values and phase out trans fats in all state agency cafeterias, public schools, public higher education institutions, mental health facilities, correctional facilities, etc. 6. Ensure that food purchases by the state and local governments are designed to provide healthy choices
	D. Develop public-private partnerships to combat obesity	1. Promote regional partnerships/collaborative to address obesity in communities 2. Develop stronger partnerships between public and private sector to expand access to community centers after school and on weekend 3. Work with local parks and recreation departments to further promote physical activity and nutrition 4. Focus on the impact of the built environment (i.e. transportation network, local land use planning) on the incidence of obesity and other chronic disease risk factors through collaboration with VDH, VDOT, Regional Planning District Commissions, VA Municipal League, and VA Association of Counties, among others
	E. Increase public awareness about the obesity issue	1. Promote and develop a statewide campaign highlighting that the third week of September is Healthy Virginians/Healthy Students Week 2. Develop PSAs with the Governor around the obesity issue 3. Work with the VCU Ad Center to develop a public campaign 4. Hold an Obesity Summit to delve further into the issues and solutions 5. Develop employer-based education/training

3. Young Adults (18 - 24)	A. Educate young adults about obesity	1. Conduct focus groups with young adults to determine what can and should be done 2. Promote nutrition courses at all colleges/universities 3. Offer healthy cooking classes 4. Ensure support for intramural activities
4. State Employees	A. Incentivize state employees to engage in a more healthy lifestyle	1. Create a Healthy Rewards program for State employees to reward those enrollees who meet their health goals with a reduction in premium, co-pays, etc. 2. Ensure that state health insurance coverage includes effective preventive measures, disease management, and obesity treatment

APPENDIX P: LISTING OF ALL TOBACCO USE RECOMMENDATIONS

Goal	Objective	Strategies
1. Decrease tobacco use among general public by X%	A. Expand Medicaid tobacco treatment coverage	1. Include telephone counseling reimbursement 2. Promote availability of Medicaid smoking cessation reimbursement to all providers
	B. Increase funding for smoking cessation	1. Increase cigarette tax and earmark money for healthcare access and prevention programs 2. Increase funding and marketing dollars for VDH Quit Line 3. Fund enforcement through state budget 4. Fund an interactive tobacco cessation website through VDH and VTSF 5. Work with stakeholders (not for profit organizations, government, etc.) to promote the use of one tobacco cessation line throughout the state 6. Address use of smokeless tobacco across all populations through marketing campaigns, educational materials, and public-private partnerships
	C. Provide comprehensive training to healthcare providers	1. Offer training on clinical guidelines for tobacco cessation to pediatricians, OB/Gyns, family practitioners, pharmacists, clinics, hospitals, VDH, and insurers 2. Educate providers on the ability to prescribe one drug to combat both depression and tobacco addiction 3. Incorporate requirements for prevention/cessation in Schools of Medicine, Dentistry, Pharmacy and Public Health to use national guidelines
	D. Support legislation to decrease smoking	1. Amend Clean Air Indoor Act A to prohibit smoking in public and private workplaces throughout the state, including restaurants, bars and hotels and support enforcement of the amendments 2. Develop legislation requiring conferences hosted by state agencies to be at smoke free hotels where such hotels are available
2. Decrease tobacco use amoung state employee by X%	A. Implement strategies to decrease tobacco use among state employees	1. Promote the VDH Quit Line to be the first resource for state employees needing assistance 2. Allow state employees to have more than 2 opportunities to participate in smoking cessation programs 3. Cover/expand nicotine replacement therapy in State Health Plan 4. Offer non-tobacco using employees a discount on the employee portion of the premium for living a health lifestyle
3. Decrease smoking and re-uptake among women by X%	A. Focus on risks of smoking to child/baby	1. Develop and fund an advertisement campaign through VDH focused on the risks of secondhand smoke to children 2. Develop and fund an advertisement campaign in partnership with March of Dimes focused on risks and affects on baby when smoking while pregnant 3. Partner with March of Dimes to provide smoking cessation programs to pregnant women 4. Add more information to the new parent toolkit concerning the harmful affects of smoking near a child and while pregnant. In addition include a resource guide for parents looking to quit smoking.

	B. Address barriers to cessation	1. Offer free enrollment at a sports/fitness club through Medicaid to address weight gain issues 2. Include partners/family members/friends in intervention efforts at VDH and Medicaid 3. Through VDH programs educate women about average weight gain after quitting smoking
4. Decrease tobacco use among young adults by X%	A. Implement strategies to decrease tobacco use among young adults	1. Assess and develop education beyond age 18 2. Develop college campaigns to promote tobacco cessation 3. Educate young adults about "Hookah" bars 4. Target young adults starting families 5. Promote smoke free college and community college campuses 24/7
5. Decrease tobacco use among teens by X%	A. Develop and implement school policies that promote tobacco cessation	1. Implement a policy requiring school-based data collection in order to develop a regional picture 2. Provide comprehensive school health education and training concerning tobacco for students, teachers, and administrators in all localities 3. Promote and create incentives for a tobacco-free school grounds 24/7 4. Develop tobacco cessation programs within schools to target the entire family
	B. Target retailers to decrease tobacco use among teens	1. Require licensure of tobacco retailers 2. Implement larger fines and suspension for selling to teens 3. Conduct retailer education campaigns
	C. Promote policies that allow at-risk youth access to tobacco cessation	1. Promote the use of tobacco intervention programs to juvenile judges where available 2. Incorporate cessation programs and smoke free policies in juvenile detention and group homes
	D. Fund marketing and treatment strategies to decrease tobacco use among teens	1. Promote public-private partnerships to increase pharmacological/nicotine replacement/cessation aids for youth including coupons for the Patch and other products 2. Develop and fund public education campaign concerning teen smoking targeted at parents 3. Implement and fund a teen Quit Line or expand VDH Quit Line to have a teen section 4. Develop an electronic QuitPack for teens based on physical package VDH sends out

APPENDIX Q: DETAILED LONG-TERM CARE WORKGROUP RECOMMENDATIONS

1A.	**Support the integration of Medicaid and Medicare acute and long-term care services for seniors and persons with disabilities:** 1. Begin implementation of the community models of integrated acute and LTC in 2007 (e.g. PACE sites). 2. Begin implementation of regional Medicaid models of integrated acute and LTC in 2008.
Agencies	DMAS
Current Activity	DMAS has worked with several localities to establish PACE sites in the Commonwealth. With new start up funds for a Northern Virginia PACE site provided by the 2007 General Assembly, Virginia will have 7 sites in development over the next two years. DMAS will continue to work with these providers to improve and extend their programs. DMAS also completed the Blueprint for Integration of Acute and LTC in December 2006. This Blueprint outlines a strategy to implement regional integrated acute and long-term care models that will combine Medicaid and Medicare funding streams and services into coordinated network of care. DMAS has begun meeting with stakeholders to discuss implementation of these regional integrated managed care models and will issue a request for proposal (RFP) to organizations interested in participating in the program in the summer 2007. DMAS will likely target the Hampton Roads and Richmond areas for the initial implementation in 2008.
Analysis	The LTC Workgroup endorses efforts by DMAS, other state, and local agencies to work together to identify, develop, and recommend an implementation plan for the Blueprint for Integration of Acute and LTC. This plan would enhance the availability, coordination, and delivery of disease management and home and community-based services to Virginia's elderly and disabled populations with an emphasis on cost-effective programs that delay, to the extent possible the need for individuals to be placed in facility-based care settings. The LTC Workgroup strongly believes the implementation plan for the Blueprint should include: • Comprehensive and effective case management for all long-term care participants to prevent decline in existing health status and to avoid unnecessary institutionalization; • Plans to ensure managed care entities provide adequate payment to providers for services; • A comprehensive system to monitor quality of care; • A plan to provide chronic disease management as a benefit to all eligible participants. Management of chronic disease will also prevent further decline in health status, promote wellness, and ensure those with the most expensive illnesses are receiving appropriate care and management; and • Appropriate consumer protections.
Estimated Annual State Cost	Not Applicable. This plan is designed to utilize existing funds.

1B.	**Maximize consumer choice for Medicaid long-term care consumers by continuing to provide consumer-directed options.**
Agencies	DMAS and DMHMRSAS
Current Activity	Four Medicaid home and community-based service waivers already provide consumer direction as an option to participants. Virginia also offers consumer direction to its Mental Retardation (MR) Waiver participants. In August 2006, DMAS was awarded a Systems Transformation Grant from the Centers for Medicare and Medicaid Services (CMS). This grant will support additional efforts to promote consumer-direction. In addition to the Systems Transformation Grant, the Money Follows the Person (MFP) grant will also work to improve and promote consumer direction for Medicaid long-term care enrollees.

	Virginia was awarded the MFP grant in May 2007.
Analysis	The LTC Workgroup supports the ongoing work of DMAS to expand consumer-direction and consumer choice within the Medicaid program. This includes support of the proposals being implemented through the Systems Transformation Grant and the MFP grant. The LTC Workgroup supports approval of the necessary budget amendments by the General Assembly during the 2008 General Assembly session to fully implement the MFP grant.
Estimated Annual State Cost	**Money Follows Person Funding Requirements** **Fiscal Year** / **State General Fund* (GF)** / **Non-General Fund (NGF)** **FY 2008** $321,611 $629,197 **FY 2009** **($381,839)** $5,206,372 **FY 2010** **($975,224)** $4,819,166 **FY 2011** **($1,623,649)** $4,316,518 * Amounts in parenthesis indicate a cost savings to the Commonwealth. With the enhanced federal match (75% vs. 50%), the Commonwealth is able to add new services to the waivers as well as provide an overall cost savings. Additional cost-savings may also accrue as a result of an increase in consumer-directed services. Studies indicate consumers use fewer services and/or use them more effectively when they are directing them. These cost-savings are not reflected in the table above because the upward trend in consumer-direction under this grant is still unknown.

1C.	**Provide an annual, automatic inflation update for Medicaid community providers, similar to nursing facility and home health reimbursement.**
Agencies	DMAS
Current Activity	Medicaid rates for many provider groups are currently augmented for inflation each year. Providers whose rates are increased annually include hospitals, nursing homes, managed care organizations, outpatient rehabilitation providers, home healthcare providers, and hospice providers. A few providers are paid their actual allowable cost, and some, such as pharmacy and durable medical equipment providers, are paid what could be called a discounted market price. However, there are some providers whose rates are not routinely updated, and therefore remain unchanged unless the initiative is taken to direct an increase through the budget process. Home and community-based waiver providers are one of these provider groups and they include adult day healthcare providers, congregate living sites, home health agencies, and personal care agencies. In order to rebalance the funding for long-term care services, community providers need to receive an annual inflator similar to the institutionalized providers.
Analysis	The proposed annual inflation adjustment (4.2%) is based on the same inflation factor used in the current nursing home reimbursement methodology. The LTC Workgroup believes that rebalancing the long-term care system requires annual, automatic inflation updates to community providers.
Estimated Annual State Cost	**Inflation Adjustment for All Home and Community Based Providers** **Fiscal Year** / **State General Fund (GF)** / **Non-General Fund (NGF)** **FY 2009** $26,345,078 $26,345,078 **FY 2010** $28,818,617 $28,818,617 **FY 2011** $31,524,397 $31,524,397

1D.	**Increase Medicaid reimbursement rates to personal care and private duty nursing providers.**

Agencies DMAS

Current Activity

Personal care providers and other community providers' Medicaid reimbursement rates are not routinely updated, and therefore remain unchanged unless the initiative is taken to direct an increase through the budget process. Personal care service providers and private duty nursing providers were frequently sighted during the public comment process as receiving inadequate payment. The low reimbursement rates make it difficult for direct care workers to earn livable wages and/or receive health benefits.

Analysis

A 10% increase in the Medicaid personal care reimbursement rate and private duty nursing reimbursement rate will likely assist community-based providers with increasing wages and possibly offering benefits. This will allow for additional training and may attract a more qualified workforce. Consumers using consumer-directed personal care will be allowed to pass the reimbursement rate increases directly on to their personal care professionals.

The LTC Workgroup also believes the any additional and future re-basing of home and community-based provider rates should be based on studies of the adequacy of current payment rates and wages to home and community-based direct support professionals.

Estimated Annual State Cost

Rebasing Personal Care at 10 Percent

Fiscal Year	State General Fund (GF)	Non-General Fund (NGF)
FY 2009	$13,366,978	$13,366,978
FY 2010	$18,347,255	$18,347,255
FY 2011	$23,101,156	$23,101,156

Rebasing Skilled/Private Duty Nursing at 10 Percent

Fiscal Year	State General Fund (GF)	Non-General Fund (NGF)
FY 2009	$2,422,930	$2,422,930
FY 2010	$3,243,600	$3,243,600
FY 2011	$4,187,370	$4,187,370

1E. Add assisted living as a Medicaid EDCD Waiver Service.

Agencies DMAS

Current Activity

Currently, assisted living is only covered for Medicaid consumers in the Alzheimer's home and community-based waiver.

Analysis

Twelve states currently offer assisted living services through a home and community-based waiver. The LTC Workgroup believes this is an important service that should be offered under the EDCD Waiver in Virginia.

Estimated Annual State Cost

Fiscal Year	Number Served	State GF	Non-GF
FY 2009	1,856	$15,671,476	$15,671,476
FY 2010	1,930	$16,337,854	$16,337,854
FY 2011	2,007	$17,030,887	$17,030,887

Assumption: Each recipient would receive personal care support, up to five hours ($66) per day, with an average of $17,952 per recipient. This payment is in addition to the Auxiliary Grant payment. Together, the AG payment and the personal care support could average $1987.50 per month (or $23,850 per year) per recipient.

The total amount of GF needed for this service was offset using current GF expenditures for intensive assisted living services ($120,960 in FY 06), and GF already set aside for the Alzheimer's Waiver, which would be included in the new service (projected $1.8 million). The estimates above reflect the difference using these expenditures.

1F.	**Expanding Medicaid case management for low-income seniors and persons with disabilities prior to meeting criteria for nursing facility care.**
Agencies	DMAS
Current Activity	At the present time, Medicaid provides limited funding for Elderly Case Management services, which is provided through several Area Agencies on Aging and one local Department of Social Services. This service targets low-income seniors with only two Activities of Daily Living (ADLs) and multiple service coordination needs, but this service is not offered statewide and is limited to persons over 60 years of age.
Analysis	The LTC Workgroup recommends establishing case management as a service for persons with two ADLs or more using a state plan option. It was assumed (using national statistics) that six percent of the aged, blind and disabled Medicaid population would have two or more ADLS at various degrees of severity. The rate for this service ($326.50/month) was modeled after existing case management rates for the MR and DD populations. It is also assumed that case management would be billed 12 months per year. Case management for Medicaid aged, blind, and disabled enrollees will help delay or prevent placement in nursing facilities or other institutions. It is estimated that the average nursing facility cost for a Medicaid enrollee is $28,391. This difference in care costs indicates that delaying or averting nursing facility care can save Medicaid funds over time.
Estimated Annual State Cost	**State Plan Case Management for 2 ADLs** **Fiscal Year** / **Number Served** / **GF** / **NGF** **FY 2009** / 12,439 / $29,022,924 / $29,022,924 **FY 2010** / 12,688 / $31,379,962 / $31,379,962 **FY 2011** / 12,942 / $33,928,488 / $33,928,488 Medicaid paid $150,850 in FY 06 for elderly case management services.

1G.	**Improve the VDSS auxiliary grant program by:** 1. Creating a pay-for-performance program for assisted living providers that accept auxiliary grants 2. Allowing family supplementation for room and board 3. Supporting local efforts to offer supportive services and case management to auxiliary grant recipients
Agencies	VDSS, DMHMRSAS, and DMAS
Current Activity	The auxiliary grant is a state supplementation program that provides a grant in addition to an SSI beneficiary's monthly SSI payment to pay for assisted living or adult foster care services. Currently, the DSS auxiliary grant program pays grant recipients $1061 per month if SSI beneficiaries live in an assisted living facility or adult foster care home. Eighty percent of the funding for this program is state General Funds; localities must pay 20 percent match. A person can qualify for the auxiliary grant program if they are SSI recipients, living in an assisted living facility or adult foster home, and meet certain functional criteria. In addition, their income must fall below the auxiliary grant payment less a monthly personal needs allowance (e.g. $1061-$75= $986). In Virginia, a person is also eligible for Medicaid if they are an SSI beneficiary, therefore all auxiliary grant participants are Medicaid eligible. However, a significant portion of participants do not qualify for long-term care services provided by Medicaid home and community-based waivers because they do not have four or more ADLs. A large percentage of auxiliary grant participants have a diagnosis of mental illness (48%), mental retardation (11%), or some combination of mental illness and mental

retardation (6%).[229] These residents may have access to supportive services such as assertive community treatment or case management, but not all do.

According to the US Department of Health and Human Services, 18 states explicitly allow families to supplement auxiliary grant or other state payments for room and board.[230] These states must treat these family supplemental payments as *in-kind income* (20 CFR416.1130 (b)) and the total SSI benefit received by the SSI client would be reduced by one-third or less, depending on the dollar amount of the family payment. This one-third deduction rule does give families in other states the ability to increase the amount of payments to assisted living providers and/or choose providers that offer a wider array of supportive services for SSI recipients.

For example, if a facility has a room and board rate of $1600, the SSI and auxiliary grant payment is not high enough to cover this amount. The family can agree to help pay. If the payment is made directly to the facility, the amount of the payment is considered *in-kind* and a one-third reduction rule applies. The SSI payment would be reduced by one-third.

During the 2007 General Assembly session, the Secretary of Health and Human Resources was required to report on the feasibility of restructuring the auxiliary grant program to pay for housing of consumers who receive case management services from a community services board or behavioral health authority. The study must include an assessment of making the auxiliary grant payments portable for these consumers so they can choose to reside in alternative living arrangements such as their own apartment. This study is due to the General Assembly on December 1, 2007 (Item 278#3h) and is currently being developed by the Department of Social Services.

Analysis

A monthly payment of $1500 is $589 less than Virginia's statewide average rate for private assisted living. The national private assisted living rate average is $2700.[231] Increasing the program payments rates might assist some auxiliary grant clients in obtaining more services or moving to higher quality assisted living facilities. However, there are several potential consequences that the LTC Workgroup considered when discussing an increase in payment rates:

- When the monthly auxiliary grant is increased, program eligibility levels rise and more people are eligible to enroll in and receive auxiliary grants. These newly eligible individuals will also qualify for Medicaid and increase Medicaid program spending.
- Localities have historically objected to the 20% local match and any increase in program funding will place an additional fiscal burden on localities.
- Increased payment levels may not be reinvested by providers in additional services or support staff.

The LTC Workgroup believes these critical factors preclude recommending a rate increase in the program without other improvements. The Workgroup learned that VDSS is currently working toward improved monitoring and oversight to ensure increased payments are appropriately invested in additional staff and improved quality for residents in all facilities. DSS is considering development of a pay for performance program to improve quality of care. This program would be based on survey and certification results and would use *new and additional* funding to encourage assisted living facilities that accept auxiliary grant clients to improve the quality of care, physical plant, and supportive services provided to residents. This program is under consideration by VDSS and the LTC Workgroup believes the VDSS should submit a budget amendment to implement

[229] VDSS analysis of Uniform Assessment Instrument data, May 2004.

[230] US Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation (April 2005). *State Residential care and Assisted Living Policy: 2004.*

[231] Genworth Financial (April 2007). *Cost of LTC Survey*.

	this program for the 2008 General Assembly session. As part of these efforts, the LTC Workgroup strongly supports efforts underway between VDSS, DMAS, and DMHRMSAS to collaborate with localities to improve services for auxiliary grant clients with mental illness and/or mental retardation. These efforts began in December 2006 and should continue on an ongoing basis to ensure coordination of services and maximum pairings of assisted living and residential living with supportive services such as case management and assertive community treatment. This will require state and local coordination and may require additional funding for community service boards to bolster the availability of supportive community mental health services. The LTC Workgroup also believes families should be allowed to supplement auxiliary grant payments for room and board. This will allow new auxiliary grant clients to choose facilities that offer more services and consequently cost more. In addition, it will provide an avenue for assisted living providers to keep a private-pay resident in their facility after their resources have been depleted. VDSS should be directed to revise its regulations to allow family supplementation.
Estimated Annual State Cost	$500,000

2A.	**Funding the State Housing Partnership Revolving Fund to support development of innovative supportive housing options for seniors and persons with disabilities.** 1. Create a program, "Living Like You" under the Fund that provides loans to encourage the development of affordable housing and the rehabilitation of existing housing for seniors and persons with disabilities. 2. Housing projects funded under this program must also provide supportive service options to their residents such as case management and transportation.
Agencies	DHCD and VHDA
Current Activity	The Commonwealth currently has a Virginia Housing Partnership Revolving Fund; however it does not have a consistent source of funding. During the 2007 General Assembly Session and previous sessions, several housing trust fund proposals were introduced. Proposals centered on updating and revising the Virginia Housing Partnership Revolving Fund to ensure there are adequate year-over-year funds allocated for a re-named Housing Trust Fund. This Housing Trust Fund would assist all citizens who have critical housing needs including low-income families, the elderly, and people with disabilities. HB1825 and SB967 proposed to allocate either excess recordation tax revenue or $0.02 per $100 of recordation tax collected to a Housing Trust Fund. However, during 2007 General Assembly session, recordation taxes were flagged to fund the state's transportation needs.
Analysis	The LTC Workgroup proposes the creation of a program, called "Living Like You", as a separate program under the Virginia Housing Partnership Revolving Fund that provides loans to encourage the development of affordable housing and the rehabilitation of existing housing for persons with disabilities and the frail elderly if a supportive services package is included in the proposal. This builds on the work of housing development corporations, AAAs, and localities that use blending funding streams from the US Department of Housing and Urban Development (HUD), state earmarks, and localities to develop housing using low or no-interest loans with extended pay-back periods. These blended models often use one entity to build and/or manage housing and a separate entity to provide supportive services to residents. The LTC Workgroup believes this model will only be effective if offered to targeted populations who wish to live with a high degree of independence and integration into the community, but have few supportive housing options. Supportive services must be a part of any development project. Providers of the service package could be the organization that owns or manages the housing, local governments, private home care agencies, non-

profit groups or other appropriate entities. Consumers enjoy maximum choice when they can select a supportive services provider who is not the housing provider, but funding would not be exclusive to these types of models. However, the separation of housing providers and supportive services providers is something the LTC Workgroup and consumer advocates encourage.

The LTC Workgroup believes these entities must work together to combine federal HUD, state, private, and other funding streams to: (a) build facilities or rehabilitate facilities for person with disabilities and frail elderly in need of housing, (b) provide creative models of supportive services like day support programs, wellness programs, and PACE-like care, and (c) apply the principles of universal design wherever possible in these facilities.[232]

The loans administered under this program would be offered at below market rate with the expectation that a certain number of multi-family units will be designated for tenants with incomes at or below 60% of the area median income. This program would function as a revolving fund with loans being paid back over an extended period of time. Loan programs have historically been more of an incentive to create housing than the Low Income Tax Credit Program and are more likely to be used by localities to attract developers.

The key ingredient to making "Living Like You" work is an ongoing commitment of State matching funds for localities. A newly dedicated source of revenue would maximize the objectives of this recommendation. The LTC Workgroup encourages the Governor and General Assembly to identify a stable, ongoing source of funds for the Revolving Partnership Fund.

The LTC Workgroup also recommends annual state funds in the amount of $5 million to support the "Living Like You Program." Each locality would be required to match state loan funds for projects. Over time, these annual funds, which will be loans, will increase the overall revolving fund. For example, with $5 million a year, by SFY2011 there would $15 million, plus interest earned in the fund available for construction, renovation, and new housing projects.

Estimated Annual State Cost	$5,000,000

3A.	**Expand VDA's *No Wrong Door* initiative statewide by 2010.**
Agencies	VDA
Current Activity	VDA, in partnership with AAAs, state agencies, Senior Navigator, and others, is developing the No Wrong Door initiative for the Commonwealth. This initiative will provide accurate and timely information to consumers, family members, providers, and state agencies that care for citizens. It will serve as a virtual resource that provides information, assessment, case management capabilities, and eligibility tools for its users. While the initiative is driven by its central website, providers that interact with consumers will use the No Wrong Door system to assist them in locating and applying for services. The goal is to help every citizen in need by improving collaboration among state and local agencies, and improved access to services and supports by using technology. No Wrong Door is a finalist for one of the 2007 Intergovernmental Solutions Awards, presented annually by the American Council for Technology. The foundation for this initiative is the Aging Disability Resource Center (ADRC) grant

[232] Universal design is a concept that encourages the construction and design of homes and other facilities to make them universally accessible to all individuals regardless of age or ability.

	that piloted No Wrong Door in three AAAs. Three additional pilot sites will be added in 2007, and additional sites will be added in 2008. VDA envisions taking No Wrong Door statewide by 2010. A statewide program will include information about services and providers as well as an online Medicaid eligibility application. Currently, Medicaid eligibility determinations for home and community-based services can take up to 45 days. The online Medicaid application is intended to shorten this determination period for consumers. Taking No Wrong Door statewide in three years requires implementation not only of the technology, but the building of relationships, collaboration, leadership at the local, regional, and state level to ensure all entities are working together to reach Virginians in need. These relationships require time and dedicated staff to work across the Commonwealth.
	The 2007 General Assembly appropriated $500,000 for No Wrong Door. This was the first state appropriation for No Wrong Door and will assist with operating and expansion costs through SFY08.
Analysis	The LTC Workgroup supports additional funding to take No Wrong Door statewide by 2010. The Workgroup believes No Wrong Door will create an important resource for families, providers, consumers, state and local agencies. The Workgroup would like to see Medicaid eligibility determinations for home and community-based services reduced from 45 days to 15 days through this statewide investment in No Wrong Door.
Estimated Annual State Cost	Preliminary estimates are: SFY09: $500,000 SFY10: $2,000,000 SFY11: $1,600,000 (for continuing and ongoing operational costs) These estimates reflect local lead agency coordination expenditures, software vendor staff and infrastructure expansion, VITA fees and management, consumer education, and support staff.

3B.	**Develop an ongoing social marketing campaign to increase the number of Virginians over age 50 with a long-term care plan and support the LTC Partnership.**
Agencies	VDA and DMAS
Current Activity	In 2005, Virginia Department for the Aging in concert with the Governor's Office, DMAS, and other state agencies launched the one-time *Own Your Future* campaign. This campaign was funded by the federal government and encouraged citizens aged 50-70 years old to plan for their future long-term care needs and consider investment in private long-term care insurance. The one-time campaign included a press conference by Governor Warner, several TV and radio public service announcements, and a letter from Governor Warner. The federal Department of Health and Human Services provided information kits to citizens that requested them after reading Governor Warner's letter. This one-time campaign was subject to the availability of federal funds. Additional federal funding became available in FFY 2007 and Virginia will launch another *Own Your Future* campaign in September 2007. This will be targeted at citizens aged 50-52 years old and will also highlight Virginia's newly established LTC Partnership. A Governor's press conference, mailings, public service announcements, as well as internet media will be part of this fall's campaign. In September 2007, DMAS will launch the LTC Partnership, which combines private LTC insurance with special access to Medicaid for individuals who exhaust their LTC insurance benefits. This model is designed to encourage individuals to purchase private LTC insurance in order to fund their LTC needs, rather than relying on Medicaid. The Centers for Healthcare Strategies recently selected Virginia to participate in *the Long-*

	term care Partnership Expansion project. The purpose of the grant is to develop a knowledge base on the implementation of Long-term care Partnership programs and provides for start-up funding for a consumer education and outreach campaign. The grant period will be July 1, 2007 – June 30, 2009 and is funded for $50,000. Many lessons about outreach and marketing will be discovered through this grant. Currently, the Virginia Insurance Counseling and Assistance Program (VICAP) receives funds to educate citizens about insurance programs in the Commonwealth. Funding for the VICAP program is limited and currently directed to Medicare Part D information and counseling. There is limited funding to educate citizens about other insurance programs, LTC planning, and services in offered the Commonwealth. A critical component of encouraging LTC planning and disseminating information about long-term care needs is the No Wrong Door program. The LTC Workgroup's recommendation to take No Wrong Door statewide (3a) by 2010 is a critical and complementary piece of reaching the public and providing quality information.
Analysis	The LTC Workgroup supports the creation of a statewide, ongoing campaign to reach citizens, particularly those ages 40-60, to encourage long-term care planning. This would require a social marketing campaign. This campaign would require development of an audience analysis, identification of community partners with extensive networks, as well as identification of private businesses partners and media outlets prior to implementation. As a first step, funding would be required to retain the appropriate staff at VDA to develop a strategic plan with these elements. The staff would then oversee the development and implementation of the campaign and help explore alternative attractive long-term care planning options such as 529 savings plans. The planning efforts would likely require at least one FTE and would be a necessary step before funding for a statewide campaign could be secured. The LTC Workgroup recommends funding for the planning process (year 1) and the first year of the social marketing campaign (year 2) in this proposal. Over time, the LTC Workgroup believes a statewide campaign will realize Medicaid savings as more people develop LTC plans that utilize private funding mechanisms and do not rely on Medicaid long-term care.
Estimated Annual State Cost	SFY09: $100,000 (one FTE and development of a strategic plan) SFY10: $500,000 (year one implementation)

3C.	**Support family and consumer rights through the LTC Ombudsman Program.**
Agencies	VDA
Current Activity	Currently, the LTC Ombudsman program in Virginia provides support to families and consumer in nursing facilities and community-settings including information, counseling on problem resolution, and complaint investigation. The Ombudsman program seeks to protect the rights of long-term care consumers and vulnerable adults.

Analysis	The current program operates with 21 FTEs and 93 volunteers. In 2005, the program services nearly 65,000 long-term care consumers. The Institute of Medicine indicates the minimum staffing required to provide a basic state LTC Ombudsman program requires 1 FTE for every 2000 long-term care beds. State law requires the same minimum standard, subject to sufficient appropriations by the General Assembly. The LTC Workgroup believes that additional funding is required to ensure Virginia's program meets the basic standards for a state Ombudsman program. This will ensure that current long-term care consumers and their families as well as future consumers have access to adequate information and support about long-term care options and consumer rights.
Estimated Annual State Cost	$913,000

4A.	**Additional funding for local mobility and Area Agency on Aging transportation programs.**
Agencies	VDA
Current Activity	Accessible transportation services are needed if seniors and persons with disabilities are to remain in their homes or community settings. These citizens need transportation in order to receive essential services such as medical care and adult day care. Caregivers are not always able to provide needed transportation for several reasons—they are not available, they are too frail themselves to manage the person they are caring for, or their vehicle is not accessible. Title IIIB of the federal Older Americans Act provides funding for Access Services including care coordination, information and assistance and transportation. States are required to spend at least 15% of their IIIB funding on access services. Because transportation is so crucial, the local Virginia Area Agencies on Aging allocated 21% of all Title IIIB funding for transportation last year.
Analysis	The LTC Workgroup supports additional funding to each AAA to expand and improve transportation services for seniors and people with disabilities. The Workgroup heard about promising local coordination pilots from Senior Connections, the Richmond-area AAA and others. The Workgroup believes transportation funding should be coordinated and leveraged with Title IIIB federal funds and local funds to ensure maximize expansion of services and innovation. The LTC Workgroup supports an additional $50,000 for each of the 25 AAAs to expand transportation services in their communities.
Estimated Annual State Cost	$1,250,000 ($50,000 each for 25 AAAs)

4B.	**Increase support and funding for family caregivers and understand the current network of community-based caregiver support organizations through:** 1. Additional funding for respite care and family caregiver programs 2. Additional education about the availability of respite care and family caregiver support programs 3. A study of the provision, cost, and availability programs that support family caregivers and long-term care consumers in the community including adult day service programs, faith-based programs, congregate meal programs, senior centers, respite programs, and home caregiver grant programs.
Agencies	VDA. VDSS, and Joint Commission on Healthcare
Current	Respite is defined as care to enable caregivers to be temporarily relieved from their care

Activity	giving responsibilities. It allows the caregiver time off to rest or take care of their own needs. The intermittent nature of respite services enables caregivers to provide care, thus preventing or delaying institutionalization. Respite care may be provided in one's home, at a respite care facility such as an adult day care, or in an institutional setting, such as a nursing home. It may be provided for a few hours each week over an extended period of time, or for several days a few times a year. Transportation may be needed in order for the consumer to take advantage of respite services outside of the home and with some funding streams, is considered to be a service that supports respite care, and is thus an allowable expense with respite funding. There are currently 700,000 estimated informal caregivers in Virginia providing 793 million caregiving hours each year at an uncompensated value of $8 million dollars per year. The National Family Caregiver Support Program, funded through Title IIIE of the Older Americans Act, provides support to these caregivers. Virginia also has a Respite Care Initiative Program that is funded by the General Assembly. This program served 364 clients in FY2006 providing 122,922 hours of respite care with an average of 6.5 hours per week per consumer. In addition the General Assembly provided funding through the VDSS Virginia Respite Care Grant program to promote the development, expansion, or start-up operations of respite care services. These are infrastructure funds to build a new facility or expand a current facility or services, and a total of $478,388 available for the biennium of July 1, 2007 through June 30, 2009. A 50% match is required by grantees awarded these funds. VDSS administers the Virginia Caregivers Grant program that provides a $500 grant annually to qualified caregivers. DMAS offers respite care services through its Home and Community Based Care waiver programs.
Analysis	During its deliberations the LTC Workgroup heard from adult day service providers as well as experts who provide care to seniors and people with disabilities in the community so that families can work and keep their loved ones at home. Many types of these programs are informal and offered locally without state or federal funding. Examples include faith-based day time senior programs. They also include private organizations and PACE programs that offer programs like adult day services, senior centers, or congregate meal programs. The vast network of day time services that support community-based long-term care consumers and the family caregivers who must work and care for children is extensive. However, little is known about its reach and the adequacy of the network to provide safe, effective respite and other care to long-term care consumers. The Workgroup believes a study of the community care network by the Joint Commission on Healthcare or another entity would assist the Secretary of Health and Human Resources and legislators in identifying needed additional funding, resources, and policies to enrich this network and ensure its continued growth as long-term care demands increase. For example, current adult day care program censuses in the Commonwealth are low and some programs have had to close because of inadequate participation. Yet, adult day care, in other areas is doing well. A study needs to determine the factors that make adult day care programs successful. In addition, tax credits and other financing options should be explored as a mechanism to support families providing care. Finally, the study should also discuss how family caregiving can be complemented and supported through the use of technology and telemedicine. New technologies provide a means to monitor long-term care consumers' health at home by professionals. This supports the family caregiver and minimizes emergencies and/or unnecessary trips to the doctor. Family caregivers are the dominant care provider for those in need of long-term care services. The Long-Term Care Workgroup strongly believes family caregivers prevent or delay institutionalization of long-term care consumers in addition they reduce reliance on more formal and state/locally funded services. Consequently, the Workgroup believes family caregivers must be provided with adequate support and assistance.

Estimated Annual State Cost	SFY09: $2,500,000 (will serve an additional 1600 consumers) SFY10: $2,500,000

5A.	**Gubernatorial designation of the Secretary as the single point of accountability for long-term care planning and implementation in the Commonwealth**
Agencies	Governor's Office
Current Activity	HB 2033 designated the Secretary of Health and Human Resources as the lead for coordinating and implementing long-term care policy for the Commonwealth. She is tasked with working with the Secretaries of Transportation, Commerce and Trade, and Education, and the Commissioner of Insurance to facilitate interagency service development and implementation, communication, and cooperation.
Analysis	Governor Kaine should use this legislation to establish a single point of accountability for long-term care planning and implementation at the state level. The Governor should designate the Secretary of Health and Human Resources as the state long-term care coordinator. The Secretary should work to identify and implement changes that would result in a simplified structure for state resources responsible for all long-term care services across state agencies.
Estimated Annual State Cost	Not Applicable

5B.	**Establishing a Long-Term Care Coordinating Council comprised of state agency heads, whose agency has service programs providing long-term care, to advise the Secretary.**
Agencies	Secretary of Health and Human Resources
Current Activity	State agencies within the Health and Human Resources Secretariat and other Secretariats provide programs to serve seniors and persons with disabilities. However, coordination and collaboration does not always occur or is done on a person-to-person or ad hoc basis. This makes it difficult to recognize service gaps, urgent issues, or regulatory issues that are limiting services for long-term care consumers.
Analysis	A Long-Term Care Coordination Council comprised of state agencies who provide long-term care services to Virginians could work on a quarterly basis to identify service gaps, regulatory concerns, and other issues that require interagency collaboration, legislation, or Governor support. The Long-Term Care Coordination Council could advise the Secretary through a yearly report on these issues and areas of concern. This report could also serve as the foundation for an annual strategic planning process for statewide long-term care coordination and implementation.
Estimated Annual State Cost	Not Applicable

5C.	**Establish a Long-Term Care Advisory Council to advise the Coordination Council (5b) and the Secretary**
Agencies	Secretary of Health and Human Resources
Current Activity	There are several entities that provide guidance to state agency heads and the Secretary of Health and Human Resources on an ad hoc basis about long-term care implementation and service coordination in the Commonwealth.
Analysis	A Long-Term Care Advisory Council could provide input to the Long-Term Care Coordination Council's quarterly planning meeting and annual report. This input would be reviewed by state agency heads, the Secretary, and the Governor. The Advisory Council would include representation from service providers, consumers, state agencies, and local government and serve as a vehicle to understand implementation and coordination issues at the frontline of long-term care services delivery.
Estimated	Not Applicable

Annual State Cost	

5D	**Support long-term care planning and coordination of services across human service, housing, transportation, and other agencies at the local level and provide funding to support planning activity.**
Agencies	Secretary of Health and Human Resources
Current Activity	Section 2.2-708 of the Code of Virginia requires the governing body of each county or city to designate a lead agency and member agencies to accomplish the coordination of local long-term care services. The agencies must establish a long-term care coordination committee composed of representatives of the local department of public health, social services, community services board, area agency on aging, and local nursing home pre-admission screening team. A plan should be implementation to ensure cost-effective utilization of funds for local long-term care services.
Analysis	This section of the Code should be amended to include participation by the housing, transportation, and other appropriate local agencies that provide long-term care services. A mechanism should also be established to provide input to the Long-Term Care Advisory Council (5c).
Estimated Annual State Cost	$0

MEMORANDUM

TO: **Dr. Timothy Garson and Karen Drenkard, Co-Chairs**
Workforce Workgroup
Governor's Health Reform Commission

CC: **Aryana Khalid, Lead Staff**
Workforce Workgroup
Governor's Health Reform Commission

FROM: **William Lukhard, Chair**
Long-Term Care Workgroup
Governor's Health Reform Commission

RE: ***Long-term care Workforce Recommendations***

Over the past several months, the Long-Term Care Workgroup of the Governor's Health Reform Commission has met to discuss the many issues facing Virginians in need of long-term care services. The adequacy and quality of the long-term care (LTC) workforce has arisen as major theme in our discussions. As with other healthcare sectors, a well-trained and adequate workforce is integral to the delivery of long-term care now and in the future. Presently, there are an inadequate number of direct care workers to provide nursing support and personal care services for long-term care consumers in Virginia and this shortage is expected to increase as the Commonwealth's population ages. In addition, many Long-Term Care Workgroup members are concerned about the training and quality of the existing direct care LTC workforce.

There are a variety of LTC direct care workers such as home health aides, certified nurse assistants (CNAs), personal care assistants, and others who provide services to long-term care consumers. Direct care workers are employed and work in a variety of settings including nursing homes, assisted living facilities, with home health agencies, or independently with long-term care consumers in their home. Consequently, they serve the majority of long-term care consumers. Our Workgroup encourages you to closely examine the unique challenges facing Virginia's direct care workforce and recommend critical steps to improve the number and quality of these long-term care workers.

This memorandum outlines the concerns of the Long-Term Care Workgroup and describes some potential initiatives we believe, with proper implementation and support, could improve Virginia's *paid* direct care workforce. The Long-Term Care Workgroup also believes this is a critical time to make improvements and take steps to bolster both our *unpaid* direct care workforce—family caregivers. The Long-Term Care Workgroup will be examining the issues unique to family caregivers during its meetings and will coordinate these findings with Commission staff to ensure they are complementary to the Workforce Workgroup recommendations and suggestions.

Recommendations

- ***Increasing Wages and Enhancing Benefits.*** Increasing wages and enhancing benefits for direct care workers will attract more workers, reduce turnover, and lead to a higher quality workforce. The Long-Term Care Workgroup recognizes that while this is the most critical factor affecting the direct care workforce, it is also the most challenging to implement with a finite state budget. *As a first step, the Workgroup recommends permanent, annual inflation updates to Medicaid home and community-based provider rates be implemented similar to those provided to Medicaid home health and nursing home providers.* Currently, Medicaid home and community-based providers receive ad hoc payment

increases. This can reduce providers' ability to raise wages and provide benefits, such as health insurance, for their direct care workers.

- ***Recruiting the Right People.*** Recruiting the right people to provide nursing support and personal care services to LTC consumers can be challenging. Wages are frequently low, benefits are minimal, and many jobs require solitary work that is isolating and can be physically demanding. However, with the appropriate supports and training, direct caregiving can be a rewarding profession for many people. The Long-Term Care Workgroup believes the following initiatives would help bring more individuals to direct care work and help make caregiving a respected profession.

    1. *Target Youth.* High schools can expose young people to the LTC profession and direct care work and provide vehicles for students to graduate with their CNA certification. Last year, Madison County offered four one-credit career/technical courses focused on healthcare. Two courses were introductory, exploring healthcareer possibilities and providing basic skills common to all health occupations. The other two allowed the student, upon completion of the course sequence, to sit for the state CNA certification exam. Other successful models that could be duplicated for CNAs include the Automotive You Education System (A-YES) and the Pharmacy Tech Training Program. These programs target students in 11th or 12th grade to receive certifications in the automotive and pharmacy technician fields, respectively. The models are partnerships between the Virginia Department of Education and Virginia trade associations.

    2. *Public-Private Partnerships.* Virginia has had great success with public-private partnerships in the past and this model can be used to promote and recruit more LTC direct care workers. John Tyler Community College recently developed a partnership with Chippenham-Johnston Willis Hospital to expand the capacity of its nursing programs. Similar models could be used with high schools, community colleges, and LTC providers to permit internships and clinical experiences for students interested in long-term care.

    3. *Incentives.* Financial incentives can be extremely effective in recruiting LTC direct care workers. Virginia could award tax credits to CNAs and other defined direct care workers. This incentive would serve as a bonus to these typically low-wage workers when/if they file taxes. In addition, agencies could work with LTC providers to provide direct financial incentives. For example, an Ohio Area Agency on Aging has partnered with local home health agencies to establish a 75-hour training program for Medicaid and Medicare-certified home health aides. Local agencies can be "preferred providers" and have direct access to new graduates for a fee. These fees are used to provide the training and provide incentives such as $50 grocery store cards when graduates have worked for more than 30 days (National Clearinghouse on the Direct Care Workforce: Best Practices, www.directcareclearinghouse.org). These are just some examples of direct incentives that use public and private resources.

    4. *Language Skills.* Twenty-four percent of home care aides and 14 percent of aides working in nursing facilities are foreign-born (National Clearinghouse on the Direct Care Workforce, "Who are Direct Care Workers? Nov 06). Long-Term Care Workgroup members that operate LTC facilities and home health agencies noted that there is a large pool of new immigrants in Virginia that may be interested in CNA, personal assistance, or other direct care work, but may not have the English-language skills necessary to sit for CNA or other certification exams. The Workgroup suggests that shortages in certain areas of the state may be ameliorated if more providers and training programs were willing to teach ESL skills as part of their CNA curricula.

    5. *Workforce Investment Boards.* Workforce Investment Boards (WIBs) administer federal Workforce Investment Act funds as well as state programs designed to assist localities with workforce investment strategies. Typically, WIB members are selected by local elected officials and are comprised of business leaders, local education systems, labor unions, and others. Hospitals, which are typically major employers, are frequently on WIBs and influence discussions around the healthcare workforce. LTC providers should consider WIBs as an important resource in their community to increase awareness about direct care workforce needs. LTC providers

should be encouraged by the Governor' Workforce Advisor to work with their local WIBs and/or serve as WIB members. In addition, WIBs are required to list job openings with the Virginia Employment Commission and with area employment services. LTC providers should be encouraged to use this vehicle to announce job openings. These two steps will help raise awareness about LTC workforce issues and direct workforce investments toward the LTC sector.

6. *TANF Recipients.* Virginia is currently updating and reforming its TANF program to comply with new federal work requirements. These requirements will reduce the number of TANF work exemptions and Virginia's Department of Social Services will be required to place more TANF recipients in the workplace than ever before. The Department of Social Services should work with LTC providers and other organizations that recruit and train CNAs and other direct care workers to place more TANF recipients in CNA and direct care worker training programs. Using partnerships with LTC providers, the Department can help ensure placement upon training graduation. Any initiatives in this area should be coupled with efforts to ensure participants have adequate access to child care during the program and once they become employed.

These are just some of many suggestions discussed by the Long-Term Care Workgroup to effectively recruit direct care workers for long-term care consumer and providers. Many of these recommendations rely heavily on local relationships between LTC providers, educational entities, and others. The Workgroup encourages you to examine methods to foster these local relationships. In cases, were initiatives can be implemented statewide, early pilot programs around the state to evaluate and determine which models for recruit and retention may work most effectively.

- ***Retaining the Right People.*** Long-Term Care Workgroup members have noted that successful recruit efforts will not improve the direct care workforce shortage unless employee turnover rates in all LTC settings are reduced. The Workgroup encourages you to consider not only recruitment, but retention during your deliberations.

  1. *Culture Change.* In nursing homes, a positive organizational culture has been proven to increase overall resident satisfaction and quality of care. In addition, it has significantly reduced employee turnover in many facilities. Initiatives such as the Eden Alternative™ and the Wellspring Innovative Solutions© have made notable gains by implementing changes that empower direct care workers and other staff. These models are duplicable and we encourage your Workgroup to examine ways the Virginia Department of Health (who licenses nursing facilities), Virginia's Quality Improvement Organizations (QIOs), and nursing facilities can work together to implement these proven models in the majority of our facilities. In addition, some of these models may be implemented at large assisted living facilities.

  2. *Continuous Training.* The Workforce Workgroup should also examine ways to ensure there is continuous ongoing training of the direct care workforce. In addition to formal training, informal programs such as peer mentoring can be effective in reducing employee turnover. Peer mentoring programs assign senior staff to new employees to assist them with the realities of their new caregiving tasks and mentor them in how to deal with patients, families, and complex issues. This helps new employees to forge relationships and cope with the new job and helps senior staff grow as professionals. This model has also proven effective in mental health settings where former patients mentor existing patients with their recovery and treatment.

- ***Align Regulation with Caregiving Realities.*** Two other issues influence the recruitment and retention of LTC direct care workers.

  1. *Barrier Crimes.* State regulations, developed to ensure vulnerable long-term care consumers are safe, may also unnecessarily exclude people that would be successful direct care workers. The Joint Commission on Healthcare is currently studying this issue with results expected in fall 2007. We encourage the Workforce Workgroup to follow this study closely and make appropriate recommendations based on its findings for the Governor's consideration and review.

2. *Training Hours.* Currently a nurse aide can choose to work in a certified home health setting where he or she would be required to obtain 75 hours of training with 16 hours of practical experience to be a CNA. The aide could also elect to work as or for a Medicaid waiver provider and obtain only 40 hours of training. They could also sit for the certified nurse aide exam, which requires 120 hours of training. However, this nurse aide would likely provide the same care across settings. This variable payment is difficult for nurse aides to manage as they try to move across providers and can be challenging for providers to manage. In addition, despite performing similar tasks, nurse aides are paid differently based on their training. This can be problematic for retention and recruitment and should be studied further.

- ***Examining State Innovations.*** Much of the discussion and research done by the LTC Workgroup with respect to direct care workers was based on the information and data from the Paraprofessional Healthcare Institute© (www.paraprofessional.org). This organization's mission is strengthening the long-term care direct care workforce and they have worked with North Carolina, Michigan, and Pennsylvania to make improvements for their workers. The LTC Workgroup encourages you to speak with the Paraprofessional Healthcare Institute© to obtain more information about innovations in other states for direct care workers and identify models that could improve Virginia's LTC workforce.

Thank you for the opportunity to share the Long-Term Care Workgroup's concerns and recommendations. As a group of long-term care stakeholders, we recognize the unique challenges with the long-term care employment sector, particularly for direct care workers. We strongly encourage the Workforce Workgroup to consider the options outlined above and to make strategic recommendations to the Commission specific to the LTC workforce. In addition, we encourage the Workforce Workgroup to recommend specific items in this memorandum for further study and consideration to the Commission.